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: 150165	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/25/2016 11:27 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2016 Time: 11:27 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 FRANCISCAN HEALTH MUNSTER (150165) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	29,939	129,597	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	29,939	129,597	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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 11:24 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 701 SUPERIOR STREET	PO Box:			1.00
2.00	City: MUNSTER	State: IN	Zip Code: 46321	County: LAKE	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	FRANCISCAN HEALTH MUNSTER	150165	23844	1	06/01/2007	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	168	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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 11:24 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)	Y	Y	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 11:24 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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 11:24 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.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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.					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:	65,519	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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 11:24 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		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: FRANCISCAN ALLIANCE,	Contractor's Name: WISCONSIN PHYSICIAN SERVICE	Contractor's Number: 8001	141.00
142.00	Street: 1515 DRAGOON TRAIL	PO Box:		142.00
143.00	City: MISHAWAKA	State:	Zip Code: 46546	143.00

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

		1.00	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.	Y		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)	9.99	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)	09/01/2015	11/29/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150165	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 11:24 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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 11:24 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)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	05/03/2016	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	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)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/04/2016	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 11:24 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				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HONG	YANG	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ST. MARGARET HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-932-2300 X33175	HONG.YANG@FRANCISCANALLIANCE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 11:24 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)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/04/2016			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR		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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2016 11:24 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	46	16,790	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		46	16,790	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9	3,285	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		55	20,075	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		55				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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2016 11:24 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)	1,764	127	2,504			1.00
2.00	HMO and other (see instructions)	199	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,764	127	2,504			7.00
8.00	INTENSIVE CARE UNIT	91	41	1,186			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,855	168	3,690	0.00	251.76	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	251.76	27.00
28.00	Observation Bed Days		68	960			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2016 11:24 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	442	34	685	1.00
2.00	HMO and other (see instructions)			53	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	442	34	685	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2016 11:24 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	16,080,992	0	16,080,992	515,649.00	31.19	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		429,433	0	429,433	1,107.00	387.93	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		23,306	0	23,306	354.10	65.82	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		164,130	0	164,130	1,259.00	130.37	13.00
14.00	Home office salaries & wage-related costs		5,360,830	0	5,360,830	160,274.00	33.45	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,431,629	0	3,431,629			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		52,414	0	52,414			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	204,368	0	204,368	8,321.00	24.56	26.00
27.00	Administrative & General	5.00	2,063,546	0	2,063,546	70,839.00	29.13	27.00
28.00	Administrative & General under contract (see inst.)		51,985	0	51,985	275.79	188.49	28.00
29.00	Maintenance & Repairs	6.00	337,337	0	337,337	11,641.00	28.98	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	290,929	0	290,929	27,621.00	10.53	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	79,724	0	79,724	5,814.00	13.71	34.00
35.00	Dietary under contract (see instructions)		5,380	0	5,380	413.75	13.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	662,878	0	662,878	17,156.00	38.64	38.00
39.00	Central Services and Supply	14.00	95,505	0	95,505	6,572.00	14.53	39.00
40.00	Pharmacy	15.00	553,343	0	553,343	11,022.00	50.20	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2016 11:24 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	194,624	0	194,624	6,020.00	32.33	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/25/2016 11:24 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		16,138,357	0	16,138,357	516,338.54	31.26	1.00
2.00	Excluded area salaries (see instructions)		429,433	0	429,433	1,107.00	387.93	2.00
3.00	Subtotal salaries (line 1 minus line 2)		15,708,924	0	15,708,924	515,231.54	30.49	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,548,266	0	5,548,266	161,887.10	34.27	4.00
5.00	Subtotal wage-related costs (see inst.)		3,431,629	0	3,431,629	0.00	21.85	5.00
6.00	Total (sum of lines 3 thru 5)		24,688,819	0	24,688,819	677,118.64	36.46	6.00
7.00	Total overhead cost (see instructions)		4,539,619	0	4,539,619	165,695.54	27.40	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2016 11:24 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	563,816	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	214,816	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,199,415	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-45	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9,433	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	128,668	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	307,126	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,051,114	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-1,737	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	11,436	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,484,042	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V Date/Time Prepared: 5/25/2016 11:24 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/25/2016 11:24 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)	0.256721	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,139,988	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	14,041,191	6.00
7.00	Medicaid cost (line 1 times line 6)	3,604,669	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)	2,464,681	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,464,681	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	62,332	3,263,496	3,325,828	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	16,002	837,808	853,810	21.00
22.00	Partial payment by patients approved for charity care	1,600	176,700	178,300	22.00
23.00	Cost of charity care (line 21 minus line 22)	14,402	661,108	675,510	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,504,071	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	157,820	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,346,251	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,115,774	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,791,284	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,255,965	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/25/2016 11:24 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	CAP REL COSTS-BLDG & FIXT		3,351,549	3,351,549	3,378,224	6,729,773	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	204,368	3,621,062	3,825,430	142,615	3,968,045	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,063,546	5,991,073	8,054,619	-195,691	7,858,928	5.00
6.00	00600	MAINTENANCE & REPAIRS	337,337	1,157,862	1,495,199	0	1,495,199	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,910	67,910	0	67,910	8.00
9.00	00900	HOUSEKEEPING	290,929	148,877	439,806	0	439,806	9.00
10.00	01000	DIETARY	79,724	133,494	213,218	0	213,218	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	662,878	15,693	678,571	0	678,571	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95,505	174,229	269,734	-5,469	264,265	14.00
15.00	01500	PHARMACY	553,343	1,474,950	2,028,293	-1,132,011	896,282	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	194,624	662,858	857,482	0	857,482	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,552,357	1,279,865	2,832,222	-17,400	2,814,822	30.00
31.00	03100	INTENSIVE CARE UNIT	1,028,551	93,066	1,121,617	-29,490	1,092,127	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,245,518	5,955,790	8,201,308	-5,356,371	2,844,937	50.00
51.00	05100	RECOVERY ROOM	1,350,251	202,843	1,553,094	-87,683	1,465,411	51.00
53.00	05300	ANESTHESIOLOGY	33,100	599,499	632,599	-93,839	538,760	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,774,837	896,228	2,671,065	-180,031	2,491,034	54.00
57.00	05700	CT SCAN	314,403	613,667	928,070	-22,285	905,785	57.00
58.00	05800	MRI	279,506	723,897	1,003,403	-610	1,002,793	58.00
59.00	05900	CARDIAC CATHETERIZATION	834,164	1,584,154	2,418,318	-1,122,628	1,295,690	59.00
60.00	06000	LABORATORY	0	3,280,038	3,280,038	0	3,280,038	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	363,445	22,858	386,303	-9,675	376,628	65.00
66.00	06600	PHYSICAL THERAPY	112,691	6,863	119,554	0	119,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	796	0	796	0	796	68.00
69.00	06900	ELECTROCARDIOLOGY	280,859	35,796	316,655	-1,968	314,687	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	420,269	742,870	1,163,139	0	1,163,139	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,229,593	2,229,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,516,679	4,516,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,340,456	1,340,456	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	134,048	9,236	143,284	0	143,284	76.01
76.02	03952	WOUND CARE	27,760	16,536	44,296	-4,476	39,820	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	483	483	0	483	90.01
90.02	09002	CLINIC	314,746	329,863	644,609	-13,558	631,051	90.02
91.00	09100	EMERGENCY	102,004	38,280	140,284	-9,229	131,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		3,325,148	3,325,148	-3,325,148	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,651,559	36,556,537	52,208,096	5	52,208,101	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	429,433	28,459	457,892	-5	457,887	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	16,080,992	36,584,996	52,665,988	0	52,665,988	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,863,879	3,865,894		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-60,000	3,908,045		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,085,780	8,944,708		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,495,199		6.00
7.00	00700	OPERATION OF PLANT	0	0		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,910		8.00
9.00	00900	HOUSEKEEPING	0	439,806		9.00
10.00	01000	DIETARY	0	213,218		10.00
11.00	01100	CAFETERIA	0	0		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	678,571		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-8,982	255,283		14.00
15.00	01500	PHARMACY	-4,759	891,523		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	370,707	1,228,189		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-255,539	2,559,283		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,092,127		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-15,663	2,829,274		50.00
51.00	05100	RECOVERY ROOM	0	1,465,411		51.00
53.00	05300	ANESTHESIOLOGY	0	538,760		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-10,701	2,480,333		54.00
57.00	05700	CT SCAN	-5,364	900,421		57.00
58.00	05800	MRI	-13,332	989,461		58.00
59.00	05900	CARDIAC CATHETERIZATION	-238,399	1,057,291		59.00
60.00	06000	LABORATORY	-4,639	3,275,399		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0		64.01
65.00	06500	RESPIRATORY THERAPY	0	376,628		65.00
66.00	06600	PHYSICAL THERAPY	0	119,554		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	796		68.00
69.00	06900	ELECTROCARDIOLOGY	-96,430	218,257		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,163,139		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,229,593		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,516,679		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,340,456		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	-2,000	141,284		76.01
76.02	03952	WOUND CARE	0	39,820		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	483		90.01
90.02	09002	CLINIC	-8,250	622,801		90.02
91.00	09100	EMERGENCY	0	131,055		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,131,450	50,076,651		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	457,887		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,131,450	50,534,538		200.00

RECLASSIFICATIONS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 11:25 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - INSURANCE				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	142,615	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	53,076	2.00
	TOTALS		0	195,691	
	B - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,325,148	1.00
	TOTALS		0	3,325,148	
	C - DRUG EXPENSE				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,340,456	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	1,340,456	
	D - MED SUPPLIES EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,229,593	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	2,229,593	
	E - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,516,679	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	4,516,679	
500.00	Grand Total: Increases		0	11,607,567	500.00

RECLASSIFICATIONS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 11:25 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	195,691	0		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	195,691			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	3,325,148	11		1.00
	TOTALS		0	3,325,148			
	C - DRUG EXPENSE						
1.00	PHARMACY	15.00	0	1,131,492	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	146	0		2.00
3.00	OPERATING ROOM	50.00	0	35	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	36,459	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	169,369	0		5.00
6.00	CT SCAN	57.00	0	29	0		6.00
7.00	CLINIC	90.02	0	2,926	0		7.00
	TOTALS		0	1,340,456			
	D - MED SUPPLIES EXPENSE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,469	0		1.00
2.00	PHARMACY	15.00	0	519	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	17,400	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	24,925	0		4.00
5.00	OPERATING ROOM	50.00	0	1,679,762	0		5.00
6.00	RECOVERY ROOM	51.00	0	87,683	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	57,380	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,662	0		8.00
9.00	CT SCAN	57.00	0	22,165	0		9.00
10.00	MRI	58.00	0	610	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	287,033	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	9,675	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	1,968	0		13.00
14.00	WOUND CARE	76.02	0	4,476	0		14.00
15.00	CLINIC	90.02	0	10,632	0		15.00
16.00	EMERGENCY	91.00	0	9,229	0		16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5	0		17.00
	TOTALS		0	2,229,593			
	E - IMPLANTABLE DEVICES						
1.00	INTENSIVE CARE UNIT	31.00	0	4,419	0		1.00
2.00	OPERATING ROOM	50.00	0	3,676,574	0		2.00
3.00	CT SCAN	57.00	0	91	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	835,595	0		4.00
	TOTALS		0	4,516,679			
500.00	Grand Total: Decreases		0	11,607,567			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2016 11:24 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: 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	7,869,989	0	0	0	0	1.00
2.00	Land Improvements	973,559	0	0	0	0	2.00
3.00	Buildings and Fixtures	26,805,106	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,693,306	2,907,923	0	2,907,923	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	57,341,960	2,907,923	0	2,907,923	0	8.00
9.00	Reconciling Items	17,302,735	34,735,496	0	34,735,496	0	9.00
10.00	Total (line 8 minus line 9)	40,039,225	-31,827,573	0	-31,827,573	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	7,869,989	0	1.00
2.00	Land Improvements	973,559	0	2.00
3.00	Buildings and Fixtures	26,805,106	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	24,601,229	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	60,249,883	0	8.00
9.00	Reconciling Items	52,038,231	0	9.00
10.00	Total (line 8 minus line 9)	8,211,652	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2016 11:24 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	CAP REL COSTS-BLDG & FIXT	3,351,549	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,351,549	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,351,549	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	3,351,549	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2016 11:24 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	CAP REL COSTS-BLDG & FIXT	3,020,833	0	3,020,833	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	3,020,833	0	3,020,833	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,232,742	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,232,742	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-366,848	0	0	0	3,865,894	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	-366,848	0	0	0	3,865,894	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/25/2016 11:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-12,483	CAP REL COSTS-BLDG & FIXT	1.00	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-241,476	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-621,504			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	-3,024,736			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-460	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PROPERTY TAXES (51009800)	A	3,737,000	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ADVERTISING (41860XXX)	A	-409,558	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/25/2016 11:25 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	
33.02	RENTAL INCOME	B	-429,307	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISCELLANEOUS - OTHER OPERATING	B	-148	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	DISCOUNTS/REBATES	B	-117	CARDIAC CATHETERIZATION	59.00	0	33.04
33.05	HAF ASSESSMENT FEES	A	-440,997	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PENSION	A	-60,000	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	MEDICAL STAFF FEES	B	-1,800	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	INTEREST INCOME - OTHER	B	-596,528	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MISCELLANEOUS REVENUE	B	-10,000	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	LOBBYING	A	-640	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PROPERTY TAXES (51009800)	A	-5,364	CT SCAN	57.00	0	33.11
33.12	PROPERTY TAXES (51009800)	A	-13,332	MRI	58.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,131,450				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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2016 11:25 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-INT	10,198	3,702,194	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	FA-NEW CAP	840,600	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	FA-A&G	6,687,629	7,217,935	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	113,272	122,254	4.00
4.01	15.00	PHARMACY	FA-COEP	41,483	46,242	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	HIM	995,888	625,181	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,689,070	11,713,806	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	FRANCISCAN ALLI	100.00		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: 150165	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/25/2016 11:25 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-3,691,996	11		1.00
2.00	840,600	9		2.00
3.00	-530,306	0		3.00
4.00	-8,982	0		4.00
4.01	-4,759	0		4.01
4.02	370,707	0		4.02
5.00	-3,024,736			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			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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2016 11:25 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	30.00	ADULTS & PEDIATRICS	250	250	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	255,289	255,289	0	0	0	2.00
3.00	50.00	OPERATING ROOM	5,500	0	5,500	200,300	44	3.00
4.00	50.00	OPERATING ROOM	11,156	0	11,156	200,300	89	4.00
5.00	50.00	OPERATING ROOM	33,000	0	33,000	200,300	220	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	701	701	0	0	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	65,500	0	65,500	200,300	524	7.00
8.00	59.00	CARDIAC CATHETERIZATION	223,242	223,242	0	0	0	8.00
9.00	60.00	LABORATORY	16,099	0	16,099	200,300	119	9.00
10.00	69.00	ELECTROCARDIOLOGY	96,430	96,430	0	0	0	10.00
11.00	76.01	CARDIAC AND PULMONARY REHAB	2,000	2,000	0	0	0	11.00
12.00	90.02	CLINIC	8,250	8,250	0	0	0	12.00
200.00			717,417	586,162	131,255		996	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	4,237	212	0	0	0	3.00
4.00	50.00	OPERATING ROOM	8,570	429	0	0	0	4.00
5.00	50.00	OPERATING ROOM	21,186	1,059	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	50,460	2,523	0	0	0	7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	11,460	573	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	76.01	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	11.00
12.00	90.02	CLINIC	0	0	0	0	0	12.00
200.00			95,913	4,796	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	30.00	ADULTS & PEDIATRICS	0	0	0	250		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	255,289		2.00
3.00	50.00	OPERATING ROOM	0	4,237	1,263	1,263		3.00
4.00	50.00	OPERATING ROOM	0	8,570	2,586	2,586		4.00
5.00	50.00	OPERATING ROOM	0	21,186	11,814	11,814		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	701		6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	50,460	15,040	15,040		7.00
8.00	59.00	CARDIAC CATHETERIZATION	0	0	0	223,242		8.00
9.00	60.00	LABORATORY	0	11,460	4,639	4,639		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	96,430		10.00
11.00	76.01	CARDIAC AND PULMONARY REHAB	0	0	0	2,000		11.00
12.00	90.02	CLINIC	0	0	0	8,250		12.00
200.00			0	95,913	35,342	621,504		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,865,894	3,865,894				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,908,045	115,014	0	4,023,059		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,944,708	229,624	0	522,892	9,697,224	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,495,199	0	0	85,480	1,580,679	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,910	0	0	0	67,910	8.00
9.00	00900	HOUSEKEEPING	439,806	0	0	73,720	513,526	9.00
10.00	01000	DIETARY	213,218	119,905	0	20,202	353,325	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	678,571	0	0	167,970	846,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	255,283	0	0	24,200	279,483	14.00
15.00	01500	PHARMACY	891,523	154,293	0	140,214	1,186,030	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,228,189	40,237	0	49,317	1,317,743	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,559,283	503,670	0	393,360	3,456,313	30.00
31.00	03100	INTENSIVE CARE UNIT	1,092,127	319,427	0	260,630	1,672,184	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,829,274	1,711,491	0	569,006	5,109,771	50.00
51.00	05100	RECOVERY ROOM	1,465,411	319,427	0	342,147	2,126,985	51.00
53.00	05300	ANESTHESIOLOGY	538,760	0	0	8,387	547,147	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,480,333	0	0	449,735	2,930,068	54.00
57.00	05700	CT SCAN	900,421	0	0	79,668	980,089	57.00
58.00	05800	MRI	989,461	0	0	70,825	1,060,286	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,057,291	0	0	211,373	1,268,664	59.00
60.00	06000	LABORATORY	3,275,399	142,595	0	0	3,417,994	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	60,860	0	0	60,860	64.01
65.00	06500	RESPIRATORY THERAPY	376,628	71,045	0	92,095	539,768	65.00
66.00	06600	PHYSICAL THERAPY	119,554	0	0	28,555	148,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	796	0	0	202	998	68.00
69.00	06900	ELECTROCARDIOLOGY	218,257	0	0	71,168	289,425	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,163,139	78,306	0	106,494	1,347,939	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,229,593	0	0	0	2,229,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,516,679	0	0	0	4,516,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,340,456	0	0	0	1,340,456	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	141,284	0	0	33,967	175,251	76.01
76.02	03952	WOUND CARE	39,820	0	0	7,034	46,854	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	483	0	0	0	483	90.01
90.02	09002	CLINIC	622,801	0	0	79,755	702,556	90.02
91.00	09100	EMERGENCY	131,055	0	0	25,847	156,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,076,651	3,865,894	0	3,914,243	49,967,835	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	457,887	0	0	108,816	566,703	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	50,534,538	3,865,894	0	4,023,059	50,534,538	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,697,224					5.00
6.00	00600	MAINTENANCE & REPAIRS	375,348	1,956,027				6.00
7.00	00700	OPERATION OF PLANT	0	0	0			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,126	0	0	84,036		8.00
9.00	00900	HOUSEKEEPING	121,942	0	0	224	635,692	9.00
10.00	01000	DIETARY	83,901	66,606	0	0	21,646	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	201,020	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,366	0	0	0	0	14.00
15.00	01500	PHARMACY	281,635	85,708	0	0	27,854	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	312,911	22,351	0	0	7,264	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	820,736	279,785	0	35,764	90,928	30.00
31.00	03100	INTENSIVE CARE UNIT	397,077	177,439	0	0	57,666	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,213,358	950,719	0	48,048	308,975	50.00
51.00	05100	RECOVERY ROOM	505,074	177,439	0	0	57,666	51.00
53.00	05300	ANESTHESIOLOGY	129,926	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	695,774	0	0	0	0	54.00
57.00	05700	CT SCAN	232,732	0	0	0	0	57.00
58.00	05800	MRI	251,776	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	301,257	0	0	0	0	59.00
60.00	06000	LABORATORY	811,637	79,210	0	0	25,743	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	14,452	33,807	0	0	10,987	64.01
65.00	06500	RESPIRATORY THERAPY	128,173	39,465	0	0	12,826	65.00
66.00	06600	PHYSICAL THERAPY	35,170	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	237	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	68,727	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	320,082	43,498	0	0	14,137	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	529,439	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,072,531	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,305	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	41,615	0	0	0	0	76.01
76.02	03952	WOUND CARE	11,126	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	115	0	0	0	0	90.01
90.02	09002	CLINIC	166,829	0	0	0	0	90.02
91.00	09100	EMERGENCY	37,258	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,562,655	1,956,027	0	84,036	635,692	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	134,569	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,697,224	1,956,027	0	84,036	635,692	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	525,478					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,047,561		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	345,849	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	23,552	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	361,401	0	0	279,135	0	30.00
31.00	03100	INTENSIVE CARE UNIT	164,077	0	0	229,385	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	212,662	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	186,602	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	67,171	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	345,849	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	27,175	0	90.02
91.00	09100	EMERGENCY	0	0	0	21,879	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	525,478	0	0	1,047,561	345,849	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	525,478	0	0	1,047,561	345,849	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,581,227					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,683,821				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	55,387	5,379,449	0	5,379,449	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,326	2,716,154	0	2,716,154	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	317,204	8,160,737	0	8,160,737	50.00
51.00	05100	RECOVERY ROOM	0	42,712	3,096,478	0	3,096,478	51.00
53.00	05300	ANESTHESIOLOGY	0	76,214	753,287	0	753,287	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	198,879	3,824,721	0	3,824,721	54.00
57.00	05700	CT SCAN	0	136,330	1,349,151	0	1,349,151	57.00
58.00	05800	MRI	0	143,168	1,455,230	0	1,455,230	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	82,757	1,719,849	0	1,719,849	59.00
60.00	06000	LABORATORY	0	242,223	4,576,807	0	4,576,807	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	120,106	0	120,106	64.01
65.00	06500	RESPIRATORY THERAPY	0	12,257	732,489	0	732,489	65.00
66.00	06600	PHYSICAL THERAPY	0	4,324	187,603	0	187,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	14	1,249	0	1,249	68.00
69.00	06900	ELECTROCARDIOLOGY	0	40,008	398,160	0	398,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	43,782	1,769,438	0	1,769,438	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	61,063	3,165,944	0	3,165,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	84,706	5,673,916	0	5,673,916	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,581,227	69,456	3,309,444	0	3,309,444	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	2,784	219,650	0	219,650	76.01
76.02	03952	WOUND CARE	0	0	57,980	0	57,980	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	598	0	598	90.01
90.02	09002	CLINIC	0	52,227	948,787	0	948,787	90.02
91.00	09100	EMERGENCY	0	0	216,039	0	216,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,581,227	1,683,821	49,833,266	0	49,833,266	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	701,272	0	701,272	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,581,227	1,683,821	50,534,538	0	50,534,538	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	115,014	0	115,014	115,014	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	229,624	0	229,624	14,948	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	2,444	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	2,107	9.00
10.00	01000	DIETARY	0	119,905	0	119,905	578	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	4,802	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	692	14.00
15.00	01500	PHARMACY	0	154,293	0	154,293	4,008	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,237	0	40,237	1,410	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	503,670	0	503,670	11,245	30.00
31.00	03100	INTENSIVE CARE UNIT	0	319,427	0	319,427	7,451	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,711,491	0	1,711,491	16,269	50.00
51.00	05100	RECOVERY ROOM	0	319,427	0	319,427	9,781	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	240	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	12,857	54.00
57.00	05700	CT SCAN	0	0	0	0	2,278	57.00
58.00	05800	MRI	0	0	0	0	2,025	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	6,043	59.00
60.00	06000	LABORATORY	0	142,595	0	142,595	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	60,860	0	60,860	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	71,045	0	71,045	2,633	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	816	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	6	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	2,035	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	78,306	0	78,306	3,044	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	971	76.01
76.02	03952	WOUND CARE	0	0	0	0	201	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	2,280	90.02
91.00	09100	EMERGENCY	0	0	0	0	739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,865,894	0	3,865,894	111,903	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,111	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,865,894	0	3,865,894	115,014	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	244,572					5.00
6.00	00600	MAINTENANCE & REPAIRS	9,467	11,911				6.00
7.00	00700	OPERATION OF PLANT	0	0	0			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	407	0	0	407		8.00
9.00	00900	HOUSEKEEPING	3,076	0	0	1	5,184	9.00
10.00	01000	DIETARY	2,116	406	0	0	177	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,070	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,674	0	0	0	0	14.00
15.00	01500	PHARMACY	7,103	522	0	0	227	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,892	136	0	0	59	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,700	1,704	0	173	742	30.00
31.00	03100	INTENSIVE CARE UNIT	10,015	1,080	0	0	470	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,597	5,790	0	233	2,519	50.00
51.00	05100	RECOVERY ROOM	12,739	1,080	0	0	470	51.00
53.00	05300	ANESTHESIOLOGY	3,277	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,548	0	0	0	0	54.00
57.00	05700	CT SCAN	5,870	0	0	0	0	57.00
58.00	05800	MRI	6,350	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,598	0	0	0	0	59.00
60.00	06000	LABORATORY	20,470	482	0	0	210	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	364	206	0	0	90	64.01
65.00	06500	RESPIRATORY THERAPY	3,233	240	0	0	105	65.00
66.00	06600	PHYSICAL THERAPY	887	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,733	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,073	265	0	0	115	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,353	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,050	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,028	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	1,050	0	0	0	0	76.01
76.02	03952	WOUND CARE	281	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	3	0	0	0	0	90.01
90.02	09002	CLINIC	4,208	0	0	0	0	90.02
91.00	09100	EMERGENCY	940	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	241,178	11,911	0	407	5,184	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,394	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	244,572	11,911	0	407	5,184	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	123,182					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	9,872		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	2,366	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	222	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,719	0	0	2,631	0	30.00
31.00	03100	INTENSIVE CARE UNIT	38,463	0	0	2,162	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,004	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,758	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	633	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,366	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	256	0	90.02
91.00	09100	EMERGENCY	0	0	0	206	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	123,182	0	0	9,872	2,366	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	123,182	0	0	9,872	2,366	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	166,153					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49,956				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,641	627,225	0	627,225	30.00
31.00	03100	INTENSIVE CARE UNIT	0	543	379,611	0	379,611	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,467	1,778,370	0	1,778,370	50.00
51.00	05100	RECOVERY ROOM	0	1,265	346,520	0	346,520	51.00
53.00	05300	ANESTHESIOLOGY	0	2,258	5,775	0	5,775	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,893	36,298	0	36,298	54.00
57.00	05700	CT SCAN	0	4,039	12,187	0	12,187	57.00
58.00	05800	MRI	0	4,242	12,617	0	12,617	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,452	16,726	0	16,726	59.00
60.00	06000	LABORATORY	0	7,177	170,934	0	170,934	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	61,520	0	61,520	64.01
65.00	06500	RESPIRATORY THERAPY	0	363	77,619	0	77,619	65.00
66.00	06600	PHYSICAL THERAPY	0	128	1,831	0	1,831	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	12	0	12	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,185	4,953	0	4,953	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,297	91,100	0	91,100	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,809	17,528	0	17,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,510	29,560	0	29,560	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	166,153	2,058	176,239	0	176,239	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	82	2,103	0	2,103	76.01
76.02	03952	WOUND CARE	0	0	482	0	482	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	3	0	3	90.01
90.02	09002	CLINIC	0	1,547	8,291	0	8,291	90.02
91.00	09100	EMERGENCY	0	0	1,885	0	1,885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	166,153	49,956	3,859,389	0	3,859,389	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,505	0	6,505	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	166,153	49,956	3,865,894	0	3,865,894	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	76,670					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		76,670				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,281	2,281	15,876,624			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,554	4,554	2,063,546	-9,697,224	40,837,314	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	337,337	0	1,580,679	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	67,910	8.00
9.00	00900	HOUSEKEEPING	0	0	290,929	0	513,526	9.00
10.00	01000	DIETARY	2,378	2,378	79,724	0	353,325	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	662,878	0	846,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	95,505	0	279,483	14.00
15.00	01500	PHARMACY	3,060	3,060	553,343	0	1,186,030	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	798	798	194,624	0	1,317,743	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,989	9,989	1,552,357	0	3,456,313	30.00
31.00	03100	INTENSIVE CARE UNIT	6,335	6,335	1,028,551	0	1,672,184	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,943	33,943	2,245,518	0	5,109,771	50.00
51.00	05100	RECOVERY ROOM	6,335	6,335	1,350,251	0	2,126,985	51.00
53.00	05300	ANESTHESIOLOGY	0	0	33,100	0	547,147	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,774,837	0	2,930,068	54.00
57.00	05700	CT SCAN	0	0	314,403	0	980,089	57.00
58.00	05800	MRI	0	0	279,506	0	1,060,286	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	834,164	0	1,268,664	59.00
60.00	06000	LABORATORY	2,828	2,828	0	0	3,417,994	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	1,207	1,207	0	0	60,860	64.01
65.00	06500	RESPIRATORY THERAPY	1,409	1,409	363,445	0	539,768	65.00
66.00	06600	PHYSICAL THERAPY	0	0	112,691	0	148,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	796	0	998	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	280,859	0	289,425	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,553	1,553	420,269	0	1,347,939	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,229,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,516,679	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,340,456	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	134,048	0	175,251	76.01
76.02	03952	WOUND CARE	0	0	27,760	0	46,854	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	483	90.01
90.02	09002	CLINIC	0	0	314,746	0	702,556	90.02
91.00	09100	EMERGENCY	0	0	102,004	0	156,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,670	76,670	15,447,191	-9,697,224	40,270,611	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	429,433	0	566,703	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,865,894	0	4,023,059		9,697,224	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	50.422512	0.000000	0.253395		0.237460	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			115,014		244,572	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.007244		0.005989	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	69,835					6.00
7.00	00700	OPERATION OF PLANT	0	69,835				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	182,638			8.00
9.00	00900	HOUSEKEEPING	0	0	486	69,835		9.00
10.00	01000	DIETARY	2,378	2,378	0	2,378	17,544	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,060	3,060	0	3,060	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	798	798	0	798	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,989	9,989	77,726	9,989	12,066	30.00
31.00	03100	INTENSIVE CARE UNIT	6,335	6,335	0	6,335	5,478	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,943	33,943	104,426	33,943	0	50.00
51.00	05100	RECOVERY ROOM	6,335	6,335	0	6,335	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,828	2,828	0	2,828	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	1,207	1,207	0	1,207	0	64.01
65.00	06500	RESPIRATORY THERAPY	1,409	1,409	0	1,409	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
70.00	07000	ELECTROENCEPHALOGRAPHY	1,553	1,553	0	1,553	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,835	69,835	182,638	69,835	17,544	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,956,027	0	84,036	635,692	525,478	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.009265	0.000000	0.460123	9.102771	29.952006	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,911	0	407	5,184	123,182	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.170559	0.000000	0.002228	0.074232	7.021318	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	CAFETERIA (NUMBER HOUSED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,517			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	100		14.00
15.00	01500	PHARMACY	0	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	169	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,003	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	1,646	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,526	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	1,339	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	482	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	100	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	195	0	0	90.02
91.00	09100	EMERGENCY	0	0	157	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	7,517	100	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	1,047,561	345,849	1,581,227	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	139.358920	3,458.490000	15,812.270000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	9,872	2,366	166,153	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	1.313290	23.660000	1,661.530000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 11:24 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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	194,114,607		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,385,358		30.00
31.00	03100	INTENSIVE CARE UNIT	2,112,703		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	36,561,444		50.00
51.00	05100	RECOVERY ROOM	4,924,086		51.00
53.00	05300	ANESTHESIOLOGY	8,786,517		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,928,199		54.00
57.00	05700	CT SCAN	15,717,035		57.00
58.00	05800	MRI	16,505,437		58.00
59.00	05900	CARDIAC CATHETERIZATION	9,540,814		59.00
60.00	06000	LABORATORY	27,925,228		60.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0		64.01
65.00	06500	RESPIRATORY THERAPY	1,413,101		65.00
66.00	06600	PHYSICAL THERAPY	498,487		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,578		68.00
69.00	06900	ELECTROCARDIOLOGY	4,612,427		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,047,539		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,039,727		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,765,536		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,007,369		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	320,949		76.01
76.02	03952	WOUND CARE	0		76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	CLINIC	0		90.01
90.02	09002	CLINIC	6,021,073		90.02
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	194,114,607		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,683,821		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008674		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,956		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000257		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 11:24 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,379,449		5,379,449	0	5,379,449	30.00
31.00	03100	INTENSIVE CARE UNIT	2,716,154		2,716,154	0	2,716,154	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,160,737		8,160,737	15,663	8,176,400	50.00
51.00	05100	RECOVERY ROOM	3,096,478		3,096,478	0	3,096,478	51.00
53.00	05300	ANESTHESIOLOGY	753,287		753,287	0	753,287	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824,721		3,824,721	0	3,824,721	54.00
57.00	05700	CT SCAN	1,349,151		1,349,151	0	1,349,151	57.00
58.00	05800	MRI	1,455,230		1,455,230	0	1,455,230	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,719,849		1,719,849	15,040	1,734,889	59.00
60.00	06000	LABORATORY	4,576,807		4,576,807	4,639	4,581,446	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	120,106		120,106	0	120,106	64.01
65.00	06500	RESPIRATORY THERAPY	732,489	0	732,489	0	732,489	65.00
66.00	06600	PHYSICAL THERAPY	187,603	0	187,603	0	187,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,249	0	1,249	0	1,249	68.00
69.00	06900	ELECTROCARDIOLOGY	398,160		398,160	0	398,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,769,438		1,769,438	0	1,769,438	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,165,944		3,165,944	0	3,165,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,673,916		5,673,916	0	5,673,916	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,309,444		3,309,444	0	3,309,444	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	219,650		219,650	0	219,650	76.01
76.02	03952	WOUND CARE	57,980		57,980	0	57,980	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	598		598	0	598	90.01
90.02	09002	CLINIC	948,787		948,787	0	948,787	90.02
91.00	09100	EMERGENCY	216,039		216,039	0	216,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,490,842		1,490,842		1,490,842	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	51,324,108	0	51,324,108	35,342	51,359,450	200.00
201.00		Less Observation Beds	1,490,842		1,490,842		1,490,842	201.00
202.00		Total (see instructions)	49,833,266	0	49,833,266	35,342	49,868,608	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 11:24 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,056,666		4,056,666			30.00
31.00	03100	INTENSIVE CARE UNIT	2,112,703		2,112,703			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,074,366	33,487,078	36,561,444	0.223206	0.000000	50.00
51.00	05100	RECOVERY ROOM	463,940	4,460,146	4,924,086	0.628843	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	999,784	7,786,733	8,786,517	0.085732	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	749,755	22,178,444	22,928,199	0.166813	0.000000	54.00
57.00	05700	CT SCAN	1,019,022	14,698,013	15,717,035	0.085840	0.000000	57.00
58.00	05800	MRI	522,174	15,983,263	16,505,437	0.088167	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,537,678	7,003,136	9,540,814	0.180262	0.000000	59.00
60.00	06000	LABORATORY	2,705,585	25,219,643	27,925,228	0.163895	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	1,326,836	86,265	1,413,101	0.518356	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	450,491	47,996	498,487	0.376345	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,578	0	1,578	0.791508	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	667,937	3,944,490	4,612,427	0.086323	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,047,539	5,047,539	0.350555	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,444,944	5,594,783	7,039,727	0.449725	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,568,867	6,196,669	9,765,536	0.581014	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,425,397	4,581,972	8,007,369	0.413300	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	709	320,240	320,949	0.684377	0.000000	76.01
76.02	03952	WOUND CARE	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	6,021,073	6,021,073	0.157578	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	884,811	1,443,881	2,328,692	0.640206	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,013,243	164,101,364	194,114,607			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	30,013,243	164,101,364	194,114,607			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 11:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.223634		50.00
51.00	05100	RECOVERY ROOM	0.628843		51.00
53.00	05300	ANESTHESIOLOGY	0.085732		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166813		54.00
57.00	05700	CT SCAN	0.085840		57.00
58.00	05800	MRI	0.088167		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.181839		59.00
60.00	06000	LABORATORY	0.164061		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000		64.01
65.00	06500	RESPIRATORY THERAPY	0.518356		65.00
66.00	06600	PHYSICAL THERAPY	0.376345		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.791508		68.00
69.00	06900	ELECTROCARDIOLOGY	0.086323		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350555		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.449725		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581014		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413300		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.684377		76.01
76.02	03952	WOUND CARE	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC	0.000000		90.01
90.02	09002	CLINIC	0.157578		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.640206		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 11:24 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,379,449		5,379,449	0	5,379,449	30.00
31.00	03100	INTENSIVE CARE UNIT	2,716,154		2,716,154	0	2,716,154	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,160,737		8,160,737	15,663	8,176,400	50.00
51.00	05100	RECOVERY ROOM	3,096,478		3,096,478	0	3,096,478	51.00
53.00	05300	ANESTHESIOLOGY	753,287		753,287	0	753,287	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824,721		3,824,721	0	3,824,721	54.00
57.00	05700	CT SCAN	1,349,151		1,349,151	0	1,349,151	57.00
58.00	05800	MRI	1,455,230		1,455,230	0	1,455,230	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,719,849		1,719,849	15,040	1,734,889	59.00
60.00	06000	LABORATORY	4,576,807		4,576,807	4,639	4,581,446	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	120,106		120,106	0	120,106	64.01
65.00	06500	RESPIRATORY THERAPY	732,489	0	732,489	0	732,489	65.00
66.00	06600	PHYSICAL THERAPY	187,603	0	187,603	0	187,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,249	0	1,249	0	1,249	68.00
69.00	06900	ELECTROCARDIOLOGY	398,160		398,160	0	398,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,769,438		1,769,438	0	1,769,438	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,165,944		3,165,944	0	3,165,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,673,916		5,673,916	0	5,673,916	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,309,444		3,309,444	0	3,309,444	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	219,650		219,650	0	219,650	76.01
76.02	03952	WOUND CARE	57,980		57,980	0	57,980	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	598		598	0	598	90.01
90.02	09002	CLINIC	948,787		948,787	0	948,787	90.02
91.00	09100	EMERGENCY	216,039		216,039	0	216,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,490,842		1,490,842		1,490,842	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	51,324,108	0	51,324,108	35,342	51,359,450	200.00
201.00		Less Observation Beds	1,490,842		1,490,842		1,490,842	201.00
202.00		Total (see instructions)	49,833,266	0	49,833,266	35,342	49,868,608	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 11:24 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	4,056,666		4,056,666			30.00
31.00	03100	INTENSIVE CARE UNIT	2,112,703		2,112,703			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,074,366	33,487,078	36,561,444	0.223206	0.000000	50.00
51.00	05100	RECOVERY ROOM	463,940	4,460,146	4,924,086	0.628843	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	999,784	7,786,733	8,786,517	0.085732	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	749,755	22,178,444	22,928,199	0.166813	0.000000	54.00
57.00	05700	CT SCAN	1,019,022	14,698,013	15,717,035	0.085840	0.000000	57.00
58.00	05800	MRI	522,174	15,983,263	16,505,437	0.088167	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,537,678	7,003,136	9,540,814	0.180262	0.000000	59.00
60.00	06000	LABORATORY	2,705,585	25,219,643	27,925,228	0.163895	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.01
65.00	06500	RESPIRATORY THERAPY	1,326,836	86,265	1,413,101	0.518356	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	450,491	47,996	498,487	0.376345	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,578	0	1,578	0.791508	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	667,937	3,944,490	4,612,427	0.086323	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,047,539	5,047,539	0.350555	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,444,944	5,594,783	7,039,727	0.449725	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,568,867	6,196,669	9,765,536	0.581014	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,425,397	4,581,972	8,007,369	0.413300	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	709	320,240	320,949	0.684377	0.000000	76.01
76.02	03952	WOUND CARE	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	6,021,073	6,021,073	0.157578	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	884,811	1,443,881	2,328,692	0.640206	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,013,243	164,101,364	194,114,607			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	30,013,243	164,101,364	194,114,607			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 11:24 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.223634		50.00
51.00	05100	RECOVERY ROOM	0.628843		51.00
53.00	05300	ANESTHESIOLOGY	0.085732		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166813		54.00
57.00	05700	CT SCAN	0.085840		57.00
58.00	05800	MRI	0.088167		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.181839		59.00
60.00	06000	LABORATORY	0.164061		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000		64.01
65.00	06500	RESPIRATORY THERAPY	0.518356		65.00
66.00	06600	PHYSICAL THERAPY	0.376345		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.791508		68.00
69.00	06900	ELECTROCARDIOLOGY	0.086323		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350555		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.449725		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581014		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413300		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.684377		76.01
76.02	03952	WOUND CARE	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC	0.000000		90.01
90.02	09002	CLINIC	0.157578		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.640206		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II | Date/Time Prepared: 5/25/2016 11:25 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	8,160,737	1,778,370	6,382,367	0	0	50.00
51.00	05100	RECOVERY ROOM	3,096,478	346,520	2,749,958	0	0	51.00
53.00	05300	ANESTHESIOLOGY	753,287	5,775	747,512	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824,721	36,298	3,788,423	0	0	54.00
57.00	05700	CT SCAN	1,349,151	12,187	1,336,964	0	0	57.00
58.00	05800	MRI	1,455,230	12,617	1,442,613	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,719,849	16,726	1,703,123	0	0	59.00
60.00	06000	LABORATORY	4,576,807	170,934	4,405,873	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	120,106	61,520	58,586	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	732,489	77,619	654,870	0	0	65.00
66.00	06600	PHYSICAL THERAPY	187,603	1,831	185,772	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,249	12	1,237	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	398,160	4,953	393,207	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,769,438	91,100	1,678,338	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,165,944	17,528	3,148,416	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,673,916	29,560	5,644,356	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,309,444	176,239	3,133,205	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	219,650	2,103	217,547	0	0	76.01
76.02	03952	WOUND CARE	57,980	482	57,498	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	598	3	595	0	0	90.01
90.02	09002	CLINIC	948,787	8,291	940,496	0	0	90.02
91.00	09100	EMERGENCY	216,039	1,885	214,154	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,490,842	173,828	1,317,014	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	43,228,505	3,026,381	40,202,124	0	0	200.00
201.00		Less Observation Beds	1,490,842	173,828	1,317,014	0	0	201.00
202.00		Total (line 200 minus line 201)	41,737,663	2,852,553	38,885,110	0	0	202.00

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

Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part II Date/Time Prepared: 5/25/2016 11:25 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	8,160,737	36,561,444	0.223206		50.00
51.00	05100	RECOVERY ROOM	3,096,478	4,924,086	0.628843		51.00
53.00	05300	ANESTHESIOLOGY	753,287	8,786,517	0.085732		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824,721	22,928,199	0.166813		54.00
57.00	05700	CT SCAN	1,349,151	15,717,035	0.085840		57.00
58.00	05800	MRI	1,455,230	16,505,437	0.088167		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,719,849	9,540,814	0.180262		59.00
60.00	06000	LABORATORY	4,576,807	27,925,228	0.163895		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000		64.00
64.01	06401	INTRAVENOUS THERAPY	120,106	0	0.000000		64.01
65.00	06500	RESPIRATORY THERAPY	732,489	1,413,101	0.518356		65.00
66.00	06600	PHYSICAL THERAPY	187,603	498,487	0.376345		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,249	1,578	0.791508		68.00
69.00	06900	ELECTROCARDIOLOGY	398,160	4,612,427	0.086323		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,769,438	5,047,539	0.350555		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,165,944	7,039,727	0.449725		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,673,916	9,765,536	0.581014		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,309,444	8,007,369	0.413300		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	219,650	320,949	0.684377		76.01
76.02	03952	WOUND CARE	57,980	0	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0.000000		90.00
90.01	09001	CLINIC	598	0	0.000000		90.01
90.02	09002	CLINIC	948,787	6,021,073	0.157578		90.02
91.00	09100	EMERGENCY	216,039	0	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,490,842	2,328,692	0.640206		92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	43,228,505	187,945,238			200.00
201.00		Less Observation Beds	1,490,842	0			201.00
202.00		Total (line 200 minus line 201)	41,737,663	187,945,238			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/25/2016 11:25 pm

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	627,225	0	627,225	3,464	181.07	30.00
31.00	INTENSIVE CARE UNIT	379,611		379,611	1,186	320.08	31.00
200.00	Total (lines 30-199)	1,006,836		1,006,836	4,650		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	1,764	319,407	30.00
31.00	INTENSIVE CARE UNIT	91	29,127	31.00
200.00	Total (lines 30-199)	1,855	348,534	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/25/2016 11:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,778,370	36,561,444	0.048641	1,201,160	58,426	50.00
51.00	05100	RECOVERY ROOM	346,520	4,924,086	0.070372	172,694	12,153	51.00
53.00	05300	ANESTHESIOLOGY	5,775	8,786,517	0.000657	368,402	242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,298	22,928,199	0.001583	398,600	631	54.00
57.00	05700	CT SCAN	12,187	15,717,035	0.000775	580,074	450	57.00
58.00	05800	MRI	12,617	16,505,437	0.000764	217,334	166	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,726	9,540,814	0.001753	1,302,337	2,283	59.00
60.00	06000	LABORATORY	170,934	27,925,228	0.006121	1,449,626	8,873	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	61,520	0	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	77,619	1,413,101	0.054928	814,480	44,738	65.00
66.00	06600	PHYSICAL THERAPY	1,831	498,487	0.003673	247,743	910	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12	1,578	0.007605	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,953	4,612,427	0.001074	387,371	416	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91,100	5,047,539	0.018048	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,528	7,039,727	0.002490	613,513	1,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,560	9,765,536	0.003027	1,397,273	4,230	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,239	8,007,369	0.022010	1,545,545	34,017	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	2,103	320,949	0.006552	0	0	76.01
76.02	03952	WOUND CARE	482	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	3	0	0.000000	0	0	90.01
90.02	09002	CLINIC	8,291	6,021,073	0.001377	0	0	90.02
91.00	09100	EMERGENCY	1,885	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	173,828	2,328,692	0.074646	447,434	33,399	92.00
200.00		Total (lines 50-199)	3,026,381	187,945,238		11,143,586	202,462	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/25/2016 11:25 pm

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,464	0.00	1,764	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,186	0.00	91	0		31.00
200.00		Total (lines 30-199)	4,650		1,855	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/25/2016 11:25 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/25/2016 11:25 pm

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		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	36,561,444	0.000000	0.000000	1,201,160	50.00
51.00	05100	RECOVERY ROOM	0	4,924,086	0.000000	0.000000	172,694	51.00
53.00	05300	ANESTHESIOLOGY	0	8,786,517	0.000000	0.000000	368,402	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,928,199	0.000000	0.000000	398,600	54.00
57.00	05700	CT SCAN	0	15,717,035	0.000000	0.000000	580,074	57.00
58.00	05800	MRI	0	16,505,437	0.000000	0.000000	217,334	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,540,814	0.000000	0.000000	1,302,337	59.00
60.00	06000	LABORATORY	0	27,925,228	0.000000	0.000000	1,449,626	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	1,413,101	0.000000	0.000000	814,480	65.00
66.00	06600	PHYSICAL THERAPY	0	498,487	0.000000	0.000000	247,743	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,578	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,612,427	0.000000	0.000000	387,371	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,047,539	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,039,727	0.000000	0.000000	613,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,765,536	0.000000	0.000000	1,397,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,007,369	0.000000	0.000000	1,545,545	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	320,949	0.000000	0.000000	0	76.01
76.02	03952	WOUND CARE	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	6,021,073	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,328,692	0.000000	0.000000	447,434	92.00
200.00		Total (lines 50-199)	0	187,945,238			11,143,586	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/25/2016 11:25 pm

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		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	8,876,908	0		50.00
51.00	05100	RECOVERY ROOM	0	1,006,808	0		51.00
53.00	05300	ANESTHESIOLOGY	0	1,643,880	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,299,202	0		54.00
57.00	05700	CT SCAN	0	4,433,134	0		57.00
58.00	05800	MRI	0	3,251,657	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,720,908	0		59.00
60.00	06000	LABORATORY	0	1,604,795	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0		64.01
65.00	06500	RESPIRATORY THERAPY	0	48,627	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	1,363,967	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,138,425	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,545,606	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,505,410	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,384,953	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0		76.01
76.02	03952	WOUND CARE	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC	0	0	0		90.01
90.02	09002	CLINIC	0	2,819,620	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	104,087	0		92.00
200.00		Total (lines 50-199)	0	39,747,987	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 11:25 pm

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		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	0.223206	8,876,908	0	0	1,981,379	50.00
51.00	05100	RECOVERY ROOM	0.628843	1,006,808	0	0	633,124	51.00
53.00	05300	ANESTHESIOLOGY	0.085732	1,643,880	0	0	140,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166813	5,299,202	0	0	883,976	54.00
57.00	05700	CT SCAN	0.085840	4,433,134	0	0	380,540	57.00
58.00	05800	MRI	0.088167	3,251,657	0	0	286,689	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.180262	2,720,908	0	0	490,476	59.00
60.00	06000	LABORATORY	0.163895	1,604,795	258	0	263,018	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.518356	48,627	0	0	25,206	65.00
66.00	06600	PHYSICAL THERAPY	0.376345	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.791508	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086323	1,363,967	0	0	117,742	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350555	1,138,425	0	0	399,081	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.449725	1,545,606	0	0	695,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581014	1,505,410	0	0	874,664	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413300	2,384,953	0	14,600	985,701	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.684377	0	0	0	0	76.01
76.02	03952	WOUND CARE	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.157578	2,819,620	0	0	444,310	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.640206	104,087	0	0	66,637	92.00
200.00		Subtotal (see instructions)		39,747,987	258	14,600	8,668,574	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		39,747,987	258	14,600	8,668,574	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 11:25 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	42	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0		64.01
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,034		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0		76.01
76.02	03952	WOUND CARE	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	42	6,034		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	42	6,034		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/25/2016 11:25 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	627,225	0	627,225	3,464	181.07	30.00
31.00	INTENSIVE CARE UNIT	379,611		379,611	1,186	320.08	31.00
200.00	Total (lines 30-199)	1,006,836		1,006,836	4,650		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	127	22,996	30.00
31.00	INTENSIVE CARE UNIT	41	13,123	31.00
200.00	Total (lines 30-199)	168	36,119	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/25/2016 11:25 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	1,778,370	36,561,444	0.048641	177,266	8,622	50.00
51.00	05100	RECOVERY ROOM	346,520	4,924,086	0.070372	24,011	1,690	51.00
53.00	05300	ANESTHESIOLOGY	5,775	8,786,517	0.000657	62,789	41	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,298	22,928,199	0.001583	36,792	58	54.00
57.00	05700	CT SCAN	12,187	15,717,035	0.000775	45,796	35	57.00
58.00	05800	MRI	12,617	16,505,437	0.000764	12,916	10	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,726	9,540,814	0.001753	128,704	226	59.00
60.00	06000	LABORATORY	170,934	27,925,228	0.006121	98,943	606	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	61,520	0	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	77,619	1,413,101	0.054928	45,540	2,501	65.00
66.00	06600	PHYSICAL THERAPY	1,831	498,487	0.003673	21,828	80	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12	1,578	0.007605	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,953	4,612,427	0.001074	28,013	30	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91,100	5,047,539	0.018048	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,528	7,039,727	0.002490	44,433	111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,560	9,765,536	0.003027	285,436	864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,239	8,007,369	0.022010	201,991	4,446	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	2,103	320,949	0.006552	0	0	76.01
76.02	03952	WOUND CARE	482	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	3	0	0.000000	0	0	90.01
90.02	09002	CLINIC	8,291	6,021,073	0.001377	0	0	90.02
91.00	09100	EMERGENCY	1,885	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	173,828	2,328,692	0.074646	0	0	92.00
200.00		Total (lines 50-199)	3,026,381	187,945,238		1,214,458	19,320	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/25/2016 11:25 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
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	3,464	0.00	127	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,186	0.00	41	0		31.00
200.00		Total (lines 30-199)	4,650		168	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/25/2016 11:25 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	76.01
76.02	03952	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/25/2016 11:25 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	36,561,444	0.000000	0.000000	177,266	50.00
51.00	05100	RECOVERY ROOM	0	4,924,086	0.000000	0.000000	24,011	51.00
53.00	05300	ANESTHESIOLOGY	0	8,786,517	0.000000	0.000000	62,789	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,928,199	0.000000	0.000000	36,792	54.00
57.00	05700	CT SCAN	0	15,717,035	0.000000	0.000000	45,796	57.00
58.00	05800	MRI	0	16,505,437	0.000000	0.000000	12,916	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,540,814	0.000000	0.000000	128,704	59.00
60.00	06000	LABORATORY	0	27,925,228	0.000000	0.000000	98,943	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.01
65.00	06500	RESPIRATORY THERAPY	0	1,413,101	0.000000	0.000000	45,540	65.00
66.00	06600	PHYSICAL THERAPY	0	498,487	0.000000	0.000000	21,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,578	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,612,427	0.000000	0.000000	28,013	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,047,539	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,039,727	0.000000	0.000000	44,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,765,536	0.000000	0.000000	285,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,007,369	0.000000	0.000000	201,991	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	320,949	0.000000	0.000000	0	76.01
76.02	03952	WOUND CARE	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	6,021,073	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,328,692	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	187,945,238			1,214,458	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/25/2016 11:25 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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
64.01	06401	INTRAVENOUS THERAPY	0	0	0		64.01
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0	0	0		76.01
76.02	03952	WOUND CARE	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 11:25 pm

Title XVIII | 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)	3,464	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,464	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,504	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,764	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,379,449	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)	5,379,449	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)	5,379,449	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)	1,552.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,739,421	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)	2,739,421	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 11:25 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,716,154	1,186	2,290.18	91	208,406	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)	3,580,730	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,528,557	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)	348,534	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	202,462	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	550,996	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,977,561	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)	960	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,552.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,490,842	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 11:25 pm

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	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	627,225	5,379,449	0.116597	1,490,842	173,828	90.00
91.00	Nursing School cost	0	5,379,449	0.000000	1,490,842	0	91.00
92.00	Allied health cost	0	5,379,449	0.000000	1,490,842	0	92.00
93.00	All other Medical Education	0	5,379,449	0.000000	1,490,842	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 11:25 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)	3,464	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,464	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,504	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)	127	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,379,449	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)	5,379,449	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)	5,379,449	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)	1,552.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	197,226	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)	197,226	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 11:25 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,716,154	1,186	2,290.18	41	93,897	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)	414,515	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	705,638	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)	36,119	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	19,320	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	55,439	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	650,199	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)	960	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,552.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,490,842	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 11:25 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	627,225	5,379,449	0.116597	1,490,842	173,828	90.00
91.00	Nursing School cost	0	5,379,449	0.000000	1,490,842	0	91.00
92.00	Allied health cost	0	5,379,449	0.000000	1,490,842	0	92.00
93.00	All other Medical Education	0	5,379,449	0.000000	1,490,842	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/25/2016 11:25 pm

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,619,338		30.00
31.00	03100	INTENSIVE CARE UNIT		1,161,741		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.223634	1,201,160	268,620	50.00
51.00	05100	RECOVERY ROOM	0.628843	172,694	108,597	51.00
53.00	05300	ANESTHESIOLOGY	0.085732	368,402	31,584	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166813	398,600	66,492	54.00
57.00	05700	CT SCAN	0.085840	580,074	49,794	57.00
58.00	05800	MRI	0.088167	217,334	19,162	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.181839	1,302,337	236,816	59.00
60.00	06000	LABORATORY	0.164061	1,449,626	237,827	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.518356	814,480	422,191	65.00
66.00	06600	PHYSICAL THERAPY	0.376345	247,743	93,237	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.791508	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086323	387,371	33,439	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350555	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.449725	613,513	275,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581014	1,397,273	811,835	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413300	1,545,545	638,774	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.684377	0	0	76.01
76.02	03952	WOUND CARE	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	90.01
90.02	09002	CLINIC	0.157578	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.640206	447,434	286,450	92.00
200.00		Total (sum of lines 50-94 and 96-98)		11,143,586	3,580,730	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)		11,143,586		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/25/2016 11:25 pm

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		190,385		30.00
31.00	03100	INTENSIVE CARE UNIT		80,831		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.223634	177,266	39,643	50.00
51.00	05100	RECOVERY ROOM	0.628843	24,011	15,099	51.00
53.00	05300	ANESTHESIOLOGY	0.085732	62,789	5,383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166813	36,792	6,137	54.00
57.00	05700	CT SCAN	0.085840	45,796	3,931	57.00
58.00	05800	MRI	0.088167	12,916	1,139	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.181839	128,704	23,403	59.00
60.00	06000	LABORATORY	0.164061	98,943	16,233	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
64.01	06401	INTRAVENOUS THERAPY	0.000000	0	0	64.01
65.00	06500	RESPIRATORY THERAPY	0.518356	45,540	23,606	65.00
66.00	06600	PHYSICAL THERAPY	0.376345	21,828	8,215	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.791508	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.086323	28,013	2,418	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350555	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.449725	44,433	19,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.581014	285,436	165,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413300	201,991	83,483	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	CARDIAC AND PULMONARY REHAB	0.684377	0	0	76.01
76.02	03952	WOUND CARE	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	90.01
90.02	09002	CLINIC	0.157578	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.640206	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,214,458	414,515	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)		1,214,458		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/25/2016 11:25 pm

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		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,664,926		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		841,518		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		160,732		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		474,045		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		52.37		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.45		30.00
31.00	Percentage of Medicaid patient days (see instructions)		4.55		31.00
32.00	Sum of lines 30 and 31		9.00		32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00		33.00
34.00	Disproportionate share adjustment (see instructions)		0		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A | Date/Time Prepared: 5/25/2016 11:25 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000001864	0.000003292	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		3,667,176		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		3,667,176		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		304,492		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		8,171		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,979,839		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,979,839		61.00
62.00	Deductibles billed to program beneficiaries		423,272		62.00
63.00	Coinsurance billed to program beneficiaries		28,035		63.00
64.00	Allowable bad debts (see instructions)		46,998		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		30,549		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,182		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,559,081		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-4,876		70.93
70.94	HRR adjustment amount (see instructions)		-1,094		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/25/2016 11:25 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		39,739		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,513,372		71.00
71.01	Sequestration adjustment (see instructions)		70,267		71.01
72.00	Interim payments		3,413,166		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		29,939		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150165	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 11:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,076	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,668,574	2.00
3.00	PPS payments	6,963,224	3.00
4.00	Outlier payment (see instructions)	20,380	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)	6,076	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	14,858	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)	14,858	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)	14,858	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	8,782	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)	6,076	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)	6,983,604	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,501,029	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)	5,488,651	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)	5,488,651	30.00
31.00	Primary payer payments	3,066	31.00
32.00	Subtotal (line 30 minus line 31)	5,485,585	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)	195,801	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	127,271	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	81,194	36.00
37.00	Subtotal (see instructions)	5,612,856	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)	5,612,856	40.00
40.01	Sequestration adjustment (see instructions)	112,257	40.01
41.00	Interim payments	5,371,002	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	129,597	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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2016 11:24 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,413,166		5,371,002	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)		3,413,166		5,371,002	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		29,939		129,597	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,443,105		5,500,599	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: 150165	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/25/2016 11:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	685	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,855	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	199	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,690	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	194,114,607	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,325,828	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/25/2016 11:25 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	64,322,445	0	0	0	1.00
2.00	Temporary investments	7,342,912	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,139,026	0	0	0	4.00
5.00	Other receivable	844,265	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,933,486	0	0	0	6.00
7.00	Inventory	1,383,742	0	0	0	7.00
8.00	Prepaid expenses	334,302	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	80,433,206	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	7,869,989	0	0	0	12.00
13.00	Land improvements	973,559	0	0	0	13.00
14.00	Accumulated depreciation	-454,743	0	0	0	14.00
15.00	Buildings	26,805,106	0	0	0	15.00
16.00	Accumulated depreciation	-4,311,098	0	0	0	16.00
17.00	Leasehold improvements	6,386,197	0	0	0	17.00
18.00	Accumulated depreciation	-2,632,409	0	0	0	18.00
19.00	Fixed equipment	76,639,460	0	0	0	19.00
20.00	Accumulated depreciation	-17,907,735	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	93,368,326	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,803,554	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,803,554	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	177,605,086	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,908,510	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,411,841	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	443,037	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	327,181	0	0	0	43.00
44.00	Other current liabilities	117,081,129	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	130,171,698	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	923,123	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	333,028	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	1,256,151	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	131,427,849	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	46,177,237				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)	46,177,237	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	177,605,086	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/25/2016 11:25 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		45,297,069		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,809,588				2.00
3.00	Total (sum of line 1 and line 2)		48,106,657		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		48,106,657		0		11.00
12.00	FUND BALANCE	1,929,420		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)		1,929,420		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		46,177,237		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	FUND BALANCE		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: 150165 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/25/2016 11:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,507,093		5,507,093	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,507,093		5,507,093	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,989,408		2,989,408	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)	2,989,408		2,989,408	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,496,501		8,496,501	17.00
18.00	Ancillary services	22,923,755	156,632,115	179,555,870	18.00
19.00	Outpatient services	0	6,021,073	6,021,073	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	0	602,472	602,472	27.00
27.01	DIETARY	0	70,454	70,454	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,420,256	163,326,114	194,746,370	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,665,988		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)		52,665,988		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150165	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/25/2016 11:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	194,746,370	1.00
2.00	Less contractual allowances and discounts on patients' accounts	140,631,122	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,115,248	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52,665,988	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,449,260	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	6,767	6.00
7.00	Income from investments	12,483	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	241,593	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	460	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	429,307	22.00
23.00	Governmental appropriations	78,127	23.00
24.00	OTHER OPERATING REVENUE	591,591	24.00
25.00	Total other income (sum of lines 6-24)	1,360,328	25.00
26.00	Total (line 5 plus line 25)	2,809,588	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,809,588	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150165	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/25/2016 11:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	280,587	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	23,905	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	10.11	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	304,492	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00