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: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/24/2016 12:33 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/24/2016 Time: 12:33 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 HEART HOSPITAL AT DEACONESS GATEWAY (150175) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/24/2016 Time: 12:33 pm
rpuovLDiBPeUyWGmPFhvcW8Q5DLIi0
RWGo:OISVvo776lftXOC.mG8FBXY2Y
2yrF0pngz4OWpE6l

PI: Date: 2/24/2016 Time: 12:33 pm
RZ3A6lMrvTeJ7lAvxg3RQxF1RIP3n0
V9mU4O2aLumfgmxnLx99D3ff5XTwd2
CzQA0Ld6ai0wEmKn

(Signed) Rebecca L. Malatte
Officer or Administrator of Provider(s)

Executive Director + CNO
Title

Feb. 24, 2016
Date

		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	42,043	71,462	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	42,043	71,462	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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2016 11:58 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4007 GATEWAY BOULEVARD	PO Box:			1.00
2.00	City: NEWBURGH	State: IN	Zip Code: 47630-	County: WARRICK	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	HEART HOSPITAL AT DEACONESS GATEWAY	150175	21780	1	02/23/2009	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	4		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	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.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 11:58 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 11:58 am

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0	0	0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 11:58 am

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0	0	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2016 11:58 am

		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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	33,865	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: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 11:58 am

		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	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)	10/03/2015	12/31/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 11:58 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2016 11:58 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

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

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	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	01/29/2016	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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/24/2016 11:58 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					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.					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					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					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.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					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.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	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.	DANIELLE	METZGER-CUNDIFF			41.00
42.00	Enter the employer/company name of the cost report preparer.	DEACONESS HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(812) 450-7423	DANIELLE.METZGER-CUNDIFF@DEACONESS.C			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2016 11:58 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				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)	01/29/2016			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.		REIMBURSEMENT ANALYST		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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/24/2016 11:58 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	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)		24	8,760	0.00	0	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)		24	8,760	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)		24				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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2016 11:58 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,363	129	6,377			1.00
2.00	HMO and other (see instructions)	1,146	214				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)	3,363	129	6,377			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)	3,363	129	6,377	0.00	140.80	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	140.80	27.00
28.00	Observation Bed Days		73	724			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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2016 11:58 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	898	24	1,718	1.00
2.00	HMO and other (see instructions)			250	45		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	898	24	1,718	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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/24/2016 11:58 am

		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	8,446,462	74,745	8,521,207	294,111.00	28.97	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		102,004	0	102,004	2,080.00	49.04	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)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		858,730	0	858,730	9,156.00	93.79	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		346,738	0	346,738	1,404.00	246.96	13.00
14.00	Home office salaries & wage-related costs		66,976	0	66,976	2,308.00	29.02	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)		2,929,972	0	2,929,972			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		17,731	0	17,731			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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	753,817	-24,666	729,151	14,811.00	49.23	27.00
28.00	Administrative & General under contract (see inst.)		158,881	0	158,881	339.00	468.68	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		241,019	0	241,019	17,162.00	14.04	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		79,732	0	79,732	4,923.00	16.20	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	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/24/2016 11:58 am

		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	0	0	0	0.00	0.00	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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 2/24/2016 11:58 am

		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)		8,926,094	74,745	9,000,839	316,535.00	28.44	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		8,926,094	74,745	9,000,839	316,535.00	28.44	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,272,444	0	1,272,444	12,868.00	98.88	4.00
5.00	Subtotal wage-related costs (see inst.)		2,929,972	0	2,929,972	0.00	32.55	5.00
6.00	Total (sum of lines 3 thru 5)		13,128,510	74,745	13,203,255	329,403.00	40.08	6.00
7.00	Total overhead cost (see instructions)		1,233,449	-24,666	1,208,783	37,235.00	32.46	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 2/24/2016 11:58 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	754,909	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)	31,619	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)	1,232,030	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	35,087	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12,464	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	22	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	130,679	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	7,180	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	639,441	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	373	19.00
20.00	State or Federal Unemployment Taxes	45,838	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	46,599	22.00
23.00	Tuition Reimbursement	11,462	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,947,703	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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 2/24/2016 11:58 am

	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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet S-10 Date/Time Prepared: 2/24/2016 11:58 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.241269	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	848,426	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	9,024,899	6.00
7.00	Medicaid cost (line 1 times line 6)	2,177,428	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)	1,329,002	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)	1,329,002	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	938,255	470,595	1,408,850	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	226,372	113,540	339,912	21.00
22.00	Partial payment by patients approved for charity care	15,872	0	15,872	22.00
23.00	Cost of charity care (line 21 minus line 22)	210,500	113,540	324,040	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,421,864	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	107,223	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,314,641	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	317,182	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	641,222	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,970,224	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,689,101	1,689,101	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,117,183	2,117,183	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,548,056	2,548,056	40,155	2,588,211	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	753,817	7,598,742	8,352,559	-3,236,409	5,116,150	5.00
7.00	00700	OPERATION OF PLANT	0	457,936	457,936	0	457,936	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,347	95,347	0	95,347	8.00
9.00	00900	HOUSEKEEPING	0	236,247	236,247	0	236,247	9.00
10.00	01000	DIETARY	0	236,323	236,323	0	236,323	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	76,049	76,049	-285	75,764	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	266,708	266,708	-30,105	236,603	14.00
15.00	01500	PHARMACY	0	2,734,028	2,734,028	-1,976,359	757,669	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	619,729	619,729	0	619,729	16.00
17.00	01700	SOCIAL SERVICE	0	162,532	162,532	0	162,532	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,061,260	1,292,173	4,353,433	-78,196	4,275,237	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	654,036	5,792,698	6,446,734	-1,689,733	4,757,001	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,696	654,550	708,246	0	708,246	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,361,636	11,343,858	13,705,494	-9,433,374	4,272,120	59.00
60.00	06000	LABORATORY	0	1,539,179	1,539,179	-3,751	1,535,428	60.00
64.00	06400	INTRAVENOUS THERAPY	447,599	262,662	710,261	-192,017	518,244	64.00
65.00	06500	RESPIRATORY THERAPY	0	251,856	251,856	-27,856	224,000	65.00
66.00	06600	PHYSICAL THERAPY	0	171,902	171,902	0	171,902	66.00
69.00	06900	ELECTROCARDIOLOGY	707,303	584,428	1,291,731	-156,958	1,134,773	69.00
69.01	06901	CARDIAC REHAB	399,451	161,618	561,069	-8,331	552,738	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,414,785	1,414,785	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,599,432	9,599,432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,977,022	1,977,022	73.00
74.00	07400	RENAL DIALYSIS	7,664	33,292	40,956	-4,130	36,826	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,446,462	37,119,913	45,566,375	174	45,566,549	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	103	103	0	103	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	24,382	24,382	0	24,382	194.01
194.02	07952	PUBLIC RELATIONS	0	26,492	26,492	0	26,492	194.02
194.03	07953	DEACONESS HOSPITAL	0	27,153	27,153	-174	26,979	194.03
200.00		TOTAL (SUM OF LINES 118-199)	8,446,462	37,198,043	45,644,505	0	45,644,505	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,689,101		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-586	2,116,597		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,588,211		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-878,651	4,237,499		5.00
7.00	00700	OPERATION OF PLANT	0	457,936		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,280	108,627		8.00
9.00	00900	HOUSEKEEPING	0	236,247		9.00
10.00	01000	DIETARY	8,712	245,035		10.00
11.00	01100	CAFETERIA	99,674	99,674		11.00
13.00	01300	NURSING ADMINISTRATION	0	75,764		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	236,603		14.00
15.00	01500	PHARMACY	0	757,669		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-41,410	578,319		16.00
17.00	01700	SOCIAL SERVICE	-1,715	160,817		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,275,237		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,780,808	2,976,193		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,131	760,377		54.00
59.00	05900	CARDIAC CATHETERIZATION	-227,919	4,044,201		59.00
60.00	06000	LABORATORY	404,644	1,940,072		60.00
64.00	06400	INTRAVENOUS THERAPY	0	518,244		64.00
65.00	06500	RESPIRATORY THERAPY	282,986	506,986		65.00
66.00	06600	PHYSICAL THERAPY	-100,850	71,052		66.00
69.00	06900	ELECTROCARDIOLOGY	-55,244	1,079,529		69.00
69.01	06901	CARDIAC REHAB	0	552,738		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	377,881	1,792,666		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,599,432		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,977,022		73.00
74.00	07400	RENAL DIALYSIS	-579	36,247		74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,848,454	43,718,095		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	103		192.00
194.00	07950	OTHER	0	0		194.00
194.01	07951	VISITOR ASSISTANTS	0	24,382		194.01
194.02	07952	PUBLIC RELATIONS	0	26,492		194.02
194.03	07953	DEACONESS HOSPITAL	0	26,979		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-1,848,454	43,796,051		200.00

RECLASSIFICATIONS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/24/2016 11:58 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EQUIPMENT DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,097,907	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
	TOTALS		0	1,097,907	
	B - LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,689,101	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	931,550	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	2,620,651	
	C - INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,119	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	20,119	
	D - PROPERTY TAXES				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	33,560	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	33,560	
	E - MEDICAL SUPPLIES AND DRUGS CHARGED				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,414,785	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,599,432	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,977,022	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
	TOTALS		0	12,991,239	
	F - PROFESSIONAL FEES				
1.00	CARDIAC CATHETERIZATION	59.00	0	339,988	1.00
2.00	RENAL DIALYSIS	74.00	0	1,238	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	341,226	
	G - INCENTIVE COMPENSATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	84,716	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	57,027	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	40,590	0	3.00
4.00	INTRAVENOUS THERAPY	64.00	4,974	0	4.00
5.00	ELECTROCARDIOLOGY	69.00	16,644	0	5.00
6.00	CARDIAC REHAB	69.01	19,132	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		223,083	0	
	H - DISABILITY				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40,155	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
	TOTALS		0	40,155	
	I - SALARIES IN NON-SALARY ACCOUNTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	25	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	375	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	300	0	3.00
4.00	CARDIAC REHAB	69.01	350	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
	TOTALS		1,050	0	

RECLASSIFICATIONS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/24/2016 11:58 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	J - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	34,047		1.00
	TOTALS		0	34,047		
500.00	Grand Total: Increases		224,133	17,178,904		500.00

RECLASSIFICATIONS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/24/2016 11:58 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EQUIPMENT DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,190	9		1.00
2.00	NURSING ADMINISTRATION	13.00	0	285	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	115,740	0		3.00
4.00	OPERATING ROOM	50.00	0	81,002	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	636,310	0		5.00
6.00	INTRAVENOUS THERAPY	64.00	0	8,987	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	171,371	0		7.00
8.00	CARDIAC REHAB	69.01	0	26,654	0		8.00
9.00	RENAL DIALYSIS	74.00	0	5,368	0		9.00
	TOTALS		0	1,097,907			
	B - LEASES						
1.00		0.00	0	0	10		1.00
2.00		0.00	0	0	10		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	2,620,651	0		3.00
	TOTALS		0	2,620,651			
	C - INSURANCE						
1.00		0.00	0	0	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	20,119	0		2.00
	TOTALS		0	20,119			
	D - PROPERTY TAXES						
1.00		0.00	0	0	13		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	33,560	0		2.00
	TOTALS		0	33,560			
	E - MEDICAL SUPPLIES AND DRUGS CHARGED						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	30,105	0		4.00
5.00	PHARMACY	15.00	0	1,976,359	0		5.00
6.00	OPERATING ROOM	50.00	0	1,607,802	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	9,167,093	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	182,024	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	27,856	0		9.00
	TOTALS		0	12,991,239			
	F - PROFESSIONAL FEES						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	337,475	0		3.00
4.00	LABORATORY	60.00	0	3,751	0		4.00
	TOTALS		0	341,226			
	G - INCENTIVE COMPENSATION						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	109,407	0	0		7.00
8.00	ADMINISTRATIVE & GENERAL	5.00	0	113,676	0		8.00
	TOTALS		109,407	113,676			
	H - DISABILITY						
1.00		0.00	0	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	19,483	0	0		2.00
3.00	OPERATING ROOM	50.00	929	0	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	10,549	0	0		4.00
5.00	INTRAVENOUS THERAPY	64.00	5,980	0	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	2,231	0	0		6.00
7.00	CARDIAC REHAB	69.01	809	0	0		7.00
8.00	DEACONESS HOSPITAL	194.03	0	174	0		8.00
	TOTALS		39,981	174			
	I - SALARIES IN NON-SALARY ACCOUNTS						
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	25	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	375	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	0	300	0		7.00
8.00	CARDIAC REHAB	69.01	0	350	0		8.00
	TOTALS		0	1,050			

RECLASSIFICATIONS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/24/2016 11:58 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,047	11		1.00
	TOTALS		0	34,047			
500.00	Grand Total: Decreases		149,388	17,253,649			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/24/2016 11:58 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	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	8,900,775	3,760,374	0	3,760,374	62,365	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,900,775	3,760,374	0	3,760,374	62,365	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,900,775	3,760,374	0	3,760,374	62,365	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,598,784	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,598,784	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	12,598,784	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/24/2016 11:58 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/24/2016 11:58 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,598,785	0	12,598,785	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	12,598,785	0	12,598,785	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	0	1,689,101	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,097,907	931,550	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,097,907	2,620,651	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	0	0	0	0	1,689,101	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	33,461	20,119	33,560	0	2,116,597	2.00
3.00	Total (sum of lines 1-2)	33,461	20,119	33,560	0	3,805,698	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/24/2016 11:58 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-586	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-116	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-287,564			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	-1,144,438			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		0		0.00	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RESEARCH	A	-415,750	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/24/2016 11:58 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,848,454				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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/24/2016 11:58 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CONTRACTED SERVICES	1,689,101	1,689,101	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CONTRACTED SERVICES	931,550	931,550	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CONTRACTED SERVICES	47,335	47,335	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES	2,036,693	2,498,366	4.00
4.01	7.00	OPERATION OF PLANT	CONTRACTED SERVICES	186,891	186,891	4.01
4.02	8.00	LAUNDRY & LINEN SERVICE	CONTRACTED SERVICES	108,627	95,347	4.02
4.03	9.00	HOUSEKEEPING	CONTRACTED SERVICES	236,247	236,247	4.03
4.04	10.00	DIETARY	CONTRACTED SERVICES	245,035	236,323	4.04
4.05	11.00	CAFETERIA	CONTRACTED SERVICES	99,674	0	4.05
4.06	13.00	NURSING ADMINISTRATION	CONTRACTED SERVICES	75,764	75,764	4.06
4.07	14.00	CENTRAL SERVICES & SUPPLY	CONTRACTED SERVICES	210,066	210,066	4.07
4.08	15.00	PHARMACY	CONTRACTED SERVICES	717,447	717,447	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	CONTRACTED SERVICES	578,319	619,729	4.09
4.10	17.00	SOCIAL SERVICE	CONTRACTED SERVICES	149,158	149,158	4.10
4.11	30.00	ADULTS & PEDIATRICS	CONTRACTED SERVICES	180,864	180,864	4.11
4.12	50.00	OPERATING ROOM	CONTRACTED SERVICES	692,424	2,473,232	4.12
4.13	54.00	RADIOLOGY-DIAGNOSTIC	CONTRACTED SERVICES	396,430	344,299	4.13
4.14	59.00	CARDIAC CATHETERIZATION	CONTRACTED SERVICES	-146,142	-146,142	4.14
4.15	60.00	LABORATORY	CONTRACTED SERVICES	1,937,898	1,532,259	4.15
4.16	64.00	INTRAVENOUS THERAPY	CONTRACTED SERVICES	362,507	362,507	4.16
4.17	65.00	RESPIRATORY THERAPY	CONTRACTED SERVICES	506,474	223,488	4.17
4.18	69.00	ELECTROCARDIOLOGY	CONTRACTED SERVICES	99,071	99,071	4.18
4.19	69.01	CARDIAC REHAB	CONTRACTED SERVICES	-18,000	-18,000	4.19
4.20	71.00	MEDICAL SUPPLIES CHARGED TO	CONTRACTED SERVICES	377,881	0	4.20
4.21	66.00	PHYSICAL THERAPY	CONTRACTED SERVICES	71,052	171,902	4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,772,366	12,916,804	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		51.00	DEACONESS HOSPI	0.00	6.00
7.00	B		51.00	DEACONESS HOSPI	0.00	7.00
8.00	B		51.00	DEACONESS HOSPI	0.00	8.00
9.00	B		51.00	DEACONESS HOSPI	0.00	9.00
10.00	B		51.00	DEACONESS HOSPI	0.00	10.00
10.01	B		51.00	DEACONESS HOSPI	0.00	10.01
10.02	B		51.00	DEACONESS HOSPI	0.00	10.02
10.03	B		51.00	DEACONESS HOSPI	0.00	10.03
10.04	B		51.00	DEACONESS HOSPI	0.00	10.04
10.05	B		51.00	DEACONESS HOSPI	0.00	10.05
10.06	B		51.00	DEACONESS HOSPI	0.00	10.06
10.07	B		51.00	DEACONESS HOSPI	0.00	10.07
10.08	B		51.00	DEACONESS HOSPI	0.00	10.08
10.09	B		51.00	DEACONESS HOSPI	0.00	10.09
10.10	B		51.00	DEACONESS HOSPI	0.00	10.10
10.11	B		51.00	DEACONESS HOSPI	0.00	10.11
10.12	B		51.00	DEACONESS HOSPI	0.00	10.12
10.13	B		51.00	DEACONESS HOSPI	0.00	10.13
10.14	B		51.00	DEACONESS HOSPI	0.00	10.14
10.15	B		51.00	DEACONESS HOSPI	0.00	10.15
10.16	B		51.00	DEACONESS HOSPI	0.00	10.16
10.17	B		51.00	DEACONESS HOSPI	0.00	10.17

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/24/2016 11:58 am

				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	
10.18	B		51.00	DEACONESS HOSPI	0.00	10.18
10.19	B		51.00	DEACONESS HOSPI	0.00	10.19
10.20	A		0.00	PROGRESSIVE HEA	51.00	10.20
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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/24/2016 11:58 am

	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	0	10		1.00
2.00	0	10		2.00
3.00	0	0		3.00
4.00	-461,673	0		4.00
4.01	0	0		4.01
4.02	13,280	0		4.02
4.03	0	0		4.03
4.04	8,712	0		4.04
4.05	99,674	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	-41,410	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	-1,780,808	0		4.12
4.13	52,131	0		4.13
4.14	0	0		4.14
4.15	405,639	0		4.15
4.16	0	0		4.16
4.17	282,986	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	377,881	0		4.20
4.21	-100,850	0		4.21
5.00	-1,144,438			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	HOSPITAL		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOSPITAL		9.00
10.00	HOSPITAL		10.00
10.01	HOSPITAL		10.01
10.02	HOSPITAL		10.02
10.03	HOSPITAL		10.03
10.04	HOSPITAL		10.04
10.05	HOSPITAL		10.05
10.06	HOSPITAL		10.06
10.07	HOSPITAL		10.07
10.08	HOSPITAL		10.08
10.09	HOSPITAL		10.09
10.10	HOSPITAL		10.10
10.11	HOSPITAL		10.11
10.12	HOSPITAL		10.12
10.13	HOSPITAL		10.13
10.14	HOSPITAL		10.14
10.15	HOSPITAL		10.15
10.16	HOSPITAL		10.16
10.17	HOSPITAL		10.17
10.18	HOSPITAL		10.18
10.19	HOSPITAL		10.19
10.20	THERAPY PROVIDE		10.20

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/24/2016 11:58 am

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/24/2016 11:58 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	2,513	0	2,513	171,400	17	1.00
2.00	17.00	SOCIAL SERVICE	1,715	1,715	0	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	339,988	0	339,988	171,400	1,360	3.00
4.00	60.00	LABORATORY	3,000	0	3,000	219,500	19	4.00
5.00	69.00	ELECTROCARDIOLOGY	55,244	55,244	0	0	0	5.00
6.00	74.00	RENAL DIALYSIS	1,238	0	1,238	171,400	8	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			403,698	56,959	346,739		1,404	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	5.00	ADMINISTRATIVE & GENERAL	1,401	70	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	0	0	0	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	112,069	5,603	0	0	0	3.00
4.00	60.00	LABORATORY	2,005	100	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	74.00	RENAL DIALYSIS	659	33	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			116,134	5,806	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	5.00	ADMINISTRATIVE & GENERAL	0	1,401	1,112	1,112		1.00
2.00	17.00	SOCIAL SERVICE	0	0	0	1,715		2.00
3.00	59.00	CARDIAC CATHETERIZATION	0	112,069	227,919	227,919		3.00
4.00	60.00	LABORATORY	0	2,005	995	995		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	55,244		5.00
6.00	74.00	RENAL DIALYSIS	0	659	579	579		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	116,134	230,605	287,564		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,689,101	1,689,101				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,116,597		2,116,597			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,588,211	0	0	2,588,211		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,237,499	13,791	100,614	221,471	4,573,375	5.00
7.00	00700	OPERATION OF PLANT	457,936	22,168	0	0	480,104	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,627	0	0	0	108,627	8.00
9.00	00900	HOUSEKEEPING	236,247	8,727	0	0	244,974	9.00
10.00	01000	DIETARY	245,035	0	0	0	245,035	10.00
11.00	01100	CAFETERIA	99,674	0	0	0	99,674	11.00
13.00	01300	NURSING ADMINISTRATION	75,764	0	549	0	76,313	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	236,603	0	0	0	236,603	14.00
15.00	01500	PHARMACY	757,669	0	0	0	757,669	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	578,319	0	0	0	578,319	16.00
17.00	01700	SOCIAL SERVICE	160,817	0	0	0	160,817	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,275,237	693,707	223,129	941,335	6,133,408	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,976,193	225,757	156,159	198,373	3,556,482	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	760,377	0	0	16,310	776,687	54.00
59.00	05900	CARDIAC CATHETERIZATION	4,044,201	511,552	1,226,709	726,534	6,508,996	59.00
60.00	06000	LABORATORY	1,940,072	0	0	0	1,940,072	60.00
64.00	06400	INTRAVENOUS THERAPY	518,244	0	17,326	135,647	671,217	64.00
65.00	06500	RESPIRATORY THERAPY	506,986	0	0	0	506,986	65.00
66.00	06600	PHYSICAL THERAPY	71,052	0	0	0	71,052	66.00
69.00	06900	ELECTROCARDIOLOGY	1,079,529	213,399	330,377	219,213	1,842,518	69.00
69.01	06901	CARDIAC REHAB	552,738	0	51,385	127,000	731,123	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,792,666	0	0	0	1,792,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,599,432	0	0	0	9,599,432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,977,022	0	0	0	1,977,022	73.00
74.00	07400	RENAL DIALYSIS	36,247	0	10,349	2,328	48,924	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,718,095	1,689,101	2,116,597	2,588,211	43,718,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	103	0	0	0	103	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	24,382	0	0	0	24,382	194.01
194.02	07952	PUBLIC RELATIONS	26,492	0	0	0	26,492	194.02
194.03	07953	DEACONESS HOSPITAL	26,979	0	0	0	26,979	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	43,796,051	1,689,101	2,116,597	2,588,211	43,796,051	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,573,375					5.00
7.00	00700	OPERATION OF PLANT	55,980	536,084				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,666	0	121,293			8.00
9.00	00900	HOUSEKEEPING	28,564	2,830	0	276,368		9.00
10.00	01000	DIETARY	28,571	0	0	0	273,606	10.00
11.00	01100	CAFETERIA	11,622	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,898	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,588	0	0	0	0	14.00
15.00	01500	PHARMACY	88,344	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67,432	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	18,751	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	715,155	224,957	75,079	116,587	269,137	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	414,686	73,209	1,190	37,942	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,562	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	758,949	165,887	32,436	85,974	4,469	59.00
60.00	06000	LABORATORY	226,212	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	78,264	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	59,115	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	8,285	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	214,838	69,201	12,588	35,865	0	69.00
69.01	06901	CARDIAC REHAB	85,249	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	209,025	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,119,303	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	230,521	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,705	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,564,285	536,084	121,293	276,368	273,606	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12	0	0	0	0	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	2,843	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	3,089	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	3,146	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,573,375	536,084	121,293	276,368	273,606	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	111,296					11.00
13.00	01300	NURSING ADMINISTRATION	0	85,211				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	264,191			14.00
15.00	01500	PHARMACY	0	0	835	846,848		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	645,751	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,199	38,439	3,481	0	49,012	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,989	7,121	33,608	0	73,475	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	832	0	4,386	0	37,381	54.00
59.00	05900	CARDIAC CATHETERIZATION	29,884	23,259	16,994	0	213,470	59.00
60.00	06000	LABORATORY	0	0	0	0	42,810	60.00
64.00	06400	INTRAVENOUS THERAPY	5,411	4,319	515	0	6,144	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	9	0	10,260	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	5,357	66.00
69.00	06900	ELECTROCARDIOLOGY	10,072	7,328	1,470	0	73,049	69.00
69.01	06901	CARDIAC REHAB	6,826	4,589	60	0	4,904	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	26,053	0	14,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	176,780	0	72,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	846,848	42,467	73.00
74.00	07400	RENAL DIALYSIS	83	156	0	0	703	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	111,296	85,211	264,191	846,848	645,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	111,296	85,211	264,191	846,848	645,751	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	179,568					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	176,633	7,850,087	0	7,850,087		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,207,702	0	4,207,702		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	909,848	0	909,848		54.00
59.00	05900	CARDIAC CATHETERIZATION	2,935	7,843,253	0	7,843,253		59.00
60.00	06000	LABORATORY	0	2,209,094	0	2,209,094		60.00
64.00	06400	INTRAVENOUS THERAPY	0	765,870	0	765,870		64.00
65.00	06500	RESPIRATORY THERAPY	0	576,370	0	576,370		65.00
66.00	06600	PHYSICAL THERAPY	0	84,694	0	84,694		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,266,929	0	2,266,929		69.00
69.01	06901	CARDIAC REHAB	0	832,751	0	832,751		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,041,968	0	2,041,968		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,968,010	0	10,968,010		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,096,858	0	3,096,858		73.00
74.00	07400	RENAL DIALYSIS	0	55,571	0	55,571		74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	179,568	43,709,005	0	43,709,005		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	115	0	115		192.00
194.00	07950	OTHER	0	0	0	0		194.00
194.01	07951	VISITOR ASSISTANTS	0	27,225	0	27,225		194.01
194.02	07952	PUBLIC RELATIONS	0	29,581	0	29,581		194.02
194.03	07953	DEACONESS HOSPITAL	0	30,125	0	30,125		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	179,568	43,796,051	0	43,796,051		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	13,791	100,614	114,405	0	5.00
7.00	00700	OPERATION OF PLANT	0	22,168	0	22,168	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,727	0	8,727	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	549	549	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	693,707	223,129	916,836	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	225,757	156,159	381,916	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	511,552	1,226,709	1,738,261	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	17,326	17,326	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	213,399	330,377	543,776	0	69.00
69.01	06901	CARDIAC REHAB	0	0	51,385	51,385	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	10,349	10,349	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,689,101	2,116,597	3,805,698	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,689,101	2,116,597	3,805,698	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	114,405					5.00
7.00	00700	OPERATION OF PLANT	1,400	23,568				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	317	0	317			8.00
9.00	00900	HOUSEKEEPING	715	124	0	9,566		9.00
10.00	01000	DIETARY	715	0	0	0	715	10.00
11.00	01100	CAFETERIA	291	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	223	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	690	0	0	0	0	14.00
15.00	01500	PHARMACY	2,210	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,687	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	469	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,891	9,890	196	4,036	703	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,374	3,219	3	1,313	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,266	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	18,987	7,293	85	2,976	12	59.00
60.00	06000	LABORATORY	5,659	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,958	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,479	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	207	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	5,375	3,042	33	1,241	0	69.00
69.01	06901	CARDIAC REHAB	2,133	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,229	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,993	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,767	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	143	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	114,178	23,568	317	9,566	715	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	71	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	77	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	79	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	114,405	23,568	317	9,566	715	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	291					11.00
13.00	01300	NURSING ADMINISTRATION	0	772				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	690			14.00
15.00	01500	PHARMACY	0	0	2	2,212		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,687	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	127	348	9	0	123	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26	65	88	0	184	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2	0	11	0	94	54.00
59.00	05900	CARDIAC CATHETERIZATION	78	211	44	0	604	59.00
60.00	06000	LABORATORY	0	0	0	0	107	60.00
64.00	06400	INTRAVENOUS THERAPY	14	39	1	0	15	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	26	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	13	66.00
69.00	06900	ELECTROCARDIOLOGY	26	66	4	0	183	69.00
69.01	06901	CARDIAC REHAB	18	42	0	0	12	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	68	0	36	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	463	0	182	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,212	106	73.00
74.00	07400	RENAL DIALYSIS	0	1	0	0	2	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	291	772	690	2,212	1,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	291	772	690	2,212	1,687	202.00

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		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	469					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	461	950,620	0	950,620		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	397,188	0	397,188		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,373	0	2,373		54.00
59.00	05900	CARDIAC CATHETERIZATION	8	1,768,559	0	1,768,559		59.00
60.00	06000	LABORATORY	0	5,766	0	5,766		60.00
64.00	06400	INTRAVENOUS THERAPY	0	19,353	0	19,353		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,505	0	1,505		65.00
66.00	06600	PHYSICAL THERAPY	0	220	0	220		66.00
69.00	06900	ELECTROCARDIOLOGY	0	553,746	0	553,746		69.00
69.01	06901	CARDIAC REHAB	0	53,590	0	53,590		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,333	0	5,333		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	28,638	0	28,638		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,085	0	8,085		73.00
74.00	07400	RENAL DIALYSIS	0	10,495	0	10,495		74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	469	3,805,471	0	3,805,471		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER	0	0	0	0		194.00
194.01	07951	VISITOR ASSISTANTS	0	71	0	71		194.01
194.02	07952	PUBLIC RELATIONS	0	77	0	77		194.02
194.03	07953	DEACONESS HOSPITAL	0	79	0	79		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	469	3,805,698	0	3,805,698		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	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	53,032					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,097,907				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,521,207			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	433	52,190	729,151	-4,573,375	39,222,676	5.00
7.00	00700	OPERATION OF PLANT	696	0	0	0	480,104	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	108,627	8.00
9.00	00900	HOUSEKEEPING	274	0	0	0	244,974	9.00
10.00	01000	DIETARY	0	0	0	0	245,035	10.00
11.00	01100	CAFETERIA	0	0	0	0	99,674	11.00
13.00	01300	NURSING ADMINISTRATION	0	285	0	0	76,313	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	236,603	14.00
15.00	01500	PHARMACY	0	0	0	0	757,669	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	578,319	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	160,817	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,780	115,740	3,099,179	0	6,133,408	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,088	81,002	653,107	0	3,556,482	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	53,696	0	776,687	54.00
59.00	05900	CARDIAC CATHETERIZATION	16,061	636,310	2,391,977	0	6,508,996	59.00
60.00	06000	LABORATORY	0	0	0	0	1,940,072	60.00
64.00	06400	INTRAVENOUS THERAPY	0	8,987	446,593	0	671,217	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	506,986	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	71,052	66.00
69.00	06900	ELECTROCARDIOLOGY	6,700	171,371	721,716	0	1,842,518	69.00
69.01	06901	CARDIAC REHAB	0	26,654	418,124	0	731,123	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,792,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,599,432	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,977,022	73.00
74.00	07400	RENAL DIALYSIS	0	5,368	7,664	0	48,924	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,032	1,097,907	8,521,207	-4,573,375	39,144,720	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	103	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	24,382	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	26,492	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	26,979	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,689,101	2,116,597	2,588,211		4,573,375	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.850600	1.927847	0.303738		0.116600	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		114,405	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.002917	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S - A)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	51,903					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	152,999				8.00
9.00	00900	HOUSEKEEPING	274	0	51,629			9.00
10.00	01000	DIETARY	0	0	0	22,041		10.00
11.00	01100	CAFETERIA	0	0	0	0	1,337	11.00
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	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,780	94,704	21,780	21,681	579	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,088	1,501	7,088	0	120	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	10	54.00
59.00	05900	CARDIAC CATHETERIZATION	16,061	40,915	16,061	360	359	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	65	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	6,700	15,879	6,700	0	121	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	82	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,903	152,999	51,629	22,041	1,337	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	536,084	121,293	276,368	273,606	111,296	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.328574	0.792770	5.352961	12.413502	83.243082	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,568	317	9,566	715	291	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.454078	0.002072	0.185283	0.032440	0.217651	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/24/2016 11:58 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	253,794					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,346,217				14.00
15.00	01500	PHARMACY	0	45,350	1,977,022			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	179,764,218		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	7,219	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	114,487	189,050	0	13,644,851	7,101	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,208	1,825,050	0	20,455,275	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	238,184	0	10,406,876	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	69,275	922,824	0	59,418,674	118	59.00
60.00	06000	LABORATORY	0	0	0	11,918,142	0	60.00
64.00	06400	INTRAVENOUS THERAPY	12,865	27,963	0	1,710,384	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	512	0	2,856,265	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,491,292	0	66.00
69.00	06900	ELECTROCARDIOLOGY	21,827	79,805	0	20,336,657	0	69.00
69.01	06901	CARDIAC REHAB	13,668	3,262	0	1,365,225	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,414,785	0	3,959,784	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,599,432	0	20,182,221	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,977,022	11,822,758	0	73.00
74.00	07400	RENAL DIALYSIS	464	0	0	195,814	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	253,794	14,346,217	1,977,022	179,764,218	7,219	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	07952	PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	07953	DEACONESS HOSPITAL	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	85,211	264,191	846,848	645,751	179,568	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.335749	0.018415	0.428345	0.003592	24.874359	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	772	690	2,212	1,687	469	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003042	0.000048	0.001119	0.000009	0.064967	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/24/2016 11:58 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,850,087		7,850,087	0	7,850,087	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,207,702		4,207,702	0	4,207,702	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	909,848		909,848	0	909,848	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,843,253		7,843,253	227,919	8,071,172	59.00
60.00	06000	LABORATORY	2,209,094		2,209,094	995	2,210,089	60.00
64.00	06400	INTRAVENOUS THERAPY	765,870		765,870	0	765,870	64.00
65.00	06500	RESPIRATORY THERAPY	576,370	0	576,370	0	576,370	65.00
66.00	06600	PHYSICAL THERAPY	84,694	0	84,694	0	84,694	66.00
69.00	06900	ELECTROCARDIOLOGY	2,266,929		2,266,929	0	2,266,929	69.00
69.01	06901	CARDIAC REHAB	832,751		832,751	0	832,751	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,041,968		2,041,968	0	2,041,968	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,968,010		10,968,010	0	10,968,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,096,858		3,096,858	0	3,096,858	73.00
74.00	07400	RENAL DIALYSIS	55,571		55,571	579	56,150	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	800,375		800,375		800,375	92.00
200.00		Subtotal (see instructions)	44,509,380	0	44,509,380	229,493	44,738,873	200.00
201.00		Less Observation Beds	800,375		800,375		800,375	201.00
202.00		Total (see instructions)	43,709,005	0	43,709,005	229,493	43,938,498	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | 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	12,699,949		12,699,949			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,676,693	915,901	20,592,594	0.204331	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,944,328	6,513,469	10,457,797	0.087002	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	24,978,211	35,082,249	60,060,460	0.130589	0.000000	59.00
60.00	06000	LABORATORY	10,224,039	1,799,677	12,023,716	0.183728	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,696,679	13,705	1,710,384	0.447777	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,845,782	24,315	2,870,097	0.200819	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,460,529	32,800	1,493,329	0.056715	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,696,511	9,745,117	20,441,628	0.110898	0.000000	69.00
69.01	06901	CARDIAC REHAB	2,089	1,386,784	1,388,873	0.599588	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,071,823	900,284	3,972,107	0.514077	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,184,914	13,117,568	20,302,482	0.540230	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,183,795	2,731,322	11,915,117	0.259910	0.000000	73.00
74.00	07400	RENAL DIALYSIS	181,830	13,984	195,814	0.283795	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	299,948	738,367	1,038,315	0.770840	0.000000	92.00
200.00		Subtotal (see instructions)	108,147,120	73,015,542	181,162,662			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	108,147,120	73,015,542	181,162,662			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/24/2016 11:58 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.204331	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087002	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134384	59.00
60.00	06000	LABORATORY	0.183811	60.00
64.00	06400	INTRAVENOUS THERAPY	0.447777	64.00
65.00	06500	RESPIRATORY THERAPY	0.200819	65.00
66.00	06600	PHYSICAL THERAPY	0.056715	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110898	69.00
69.01	06901	CARDIAC REHAB	0.599588	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.514077	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.540230	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259910	73.00
74.00	07400	RENAL DIALYSIS	0.286752	74.00
		OUTPATIENT SERVICE COST CENTERS		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770840	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/24/2016 11:58 am

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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	7,850,087		7,850,087	0	7,850,087	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,207,702		4,207,702	0	4,207,702	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	909,848		909,848	0	909,848	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,843,253		7,843,253	227,919	8,071,172	59.00
60.00	06000	LABORATORY	2,209,094		2,209,094	995	2,210,089	60.00
64.00	06400	INTRAVENOUS THERAPY	765,870		765,870	0	765,870	64.00
65.00	06500	RESPIRATORY THERAPY	576,370	0	576,370	0	576,370	65.00
66.00	06600	PHYSICAL THERAPY	84,694	0	84,694	0	84,694	66.00
69.00	06900	ELECTROCARDIOLOGY	2,266,929		2,266,929	0	2,266,929	69.00
69.01	06901	CARDIAC REHAB	832,751		832,751	0	832,751	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,041,968		2,041,968	0	2,041,968	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,968,010		10,968,010	0	10,968,010	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,096,858		3,096,858	0	3,096,858	73.00
74.00	07400	RENAL DIALYSIS	55,571		55,571	579	56,150	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	800,375		800,375		800,375	92.00
200.00		Subtotal (see instructions)	44,509,380	0	44,509,380	229,493	44,738,873	200.00
201.00		Less Observation Beds	800,375		800,375		800,375	201.00
202.00		Total (see instructions)	43,709,005	0	43,709,005	229,493	43,938,498	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/24/2016 11:58 am

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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	12,699,949		12,699,949			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,676,693	915,901	20,592,594	0.204331	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,944,328	6,513,469	10,457,797	0.087002	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	24,978,211	35,082,249	60,060,460	0.130589	0.000000	59.00
60.00	06000	LABORATORY	10,224,039	1,799,677	12,023,716	0.183728	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,696,679	13,705	1,710,384	0.447777	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,845,782	24,315	2,870,097	0.200819	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,460,529	32,800	1,493,329	0.056715	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	10,696,511	9,745,117	20,441,628	0.110898	0.000000	69.00
69.01	06901	CARDIAC REHAB	2,089	1,386,784	1,388,873	0.599588	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,071,823	900,284	3,972,107	0.514077	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,184,914	13,117,568	20,302,482	0.540230	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,183,795	2,731,322	11,915,117	0.259910	0.000000	73.00
74.00	07400	RENAL DIALYSIS	181,830	13,984	195,814	0.283795	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	299,948	738,367	1,038,315	0.770840	0.000000	92.00
200.00		Subtotal (see instructions)	108,147,120	73,015,542	181,162,662			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	108,147,120	73,015,542	181,162,662			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/24/2016 11:58 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.204331		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087002		54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134384		59.00
60.00	06000	LABORATORY	0.183811		60.00
64.00	06400	INTRAVENOUS THERAPY	0.447777		64.00
65.00	06500	RESPIRATORY THERAPY	0.200819		65.00
66.00	06600	PHYSICAL THERAPY	0.056715		66.00
69.00	06900	ELECTROCARDIOLOGY	0.110898		69.00
69.01	06901	CARDIAC REHAB	0.599588		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.514077		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.540230		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259910		73.00
74.00	07400	RENAL DIALYSIS	0.286752		74.00
		OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770840		92.00
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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/24/2016 11:58 am

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	4,207,702	397,188	3,810,514	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	909,848	2,373	907,475	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,843,253	1,768,559	6,074,694	0	0	59.00
60.00	06000	LABORATORY	2,209,094	5,766	2,203,328	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	765,870	19,353	746,517	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	576,370	1,505	574,865	0	0	65.00
66.00	06600	PHYSICAL THERAPY	84,694	220	84,474	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,266,929	553,746	1,713,183	0	0	69.00
69.01	06901	CARDIAC REHAB	832,751	53,590	779,161	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,041,968	5,333	2,036,635	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,968,010	28,638	10,939,372	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,096,858	8,085	3,088,773	0	0	73.00
74.00	07400	RENAL DIALYSIS	55,571	10,495	45,076	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	800,375	96,923	703,452	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	36,659,293	2,951,774	33,707,519	0	0	200.00
201.00		Less Observation Beds	800,375	96,923	703,452	0	0	201.00
202.00		Total (line 200 minus line 201)	35,858,918	2,854,851	33,004,067	0	0	202.00

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

Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/24/2016 11:58 am

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	4,207,702	20,592,594	0.204331		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	909,848	10,457,797	0.087002		54.00
59.00	05900	CARDIAC CATHETERIZATION	7,843,253	60,060,460	0.130589		59.00
60.00	06000	LABORATORY	2,209,094	12,023,716	0.183728		60.00
64.00	06400	INTRAVENOUS THERAPY	765,870	1,710,384	0.447777		64.00
65.00	06500	RESPIRATORY THERAPY	576,370	2,870,097	0.200819		65.00
66.00	06600	PHYSICAL THERAPY	84,694	1,493,329	0.056715		66.00
69.00	06900	ELECTROCARDIOLOGY	2,266,929	20,441,628	0.110898		69.00
69.01	06901	CARDIAC REHAB	832,751	1,388,873	0.599588		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,041,968	3,972,107	0.514077		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,968,010	20,302,482	0.540230		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,096,858	11,915,117	0.259910		73.00
74.00	07400	RENAL DIALYSIS	55,571	195,814	0.283795		74.00
		OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	800,375	1,038,315	0.770840		92.00
200.00		Subtotal (sum of lines 50 thru 199)	36,659,293	168,462,713			200.00
201.00		Less Observation Beds	800,375	0			201.00
202.00		Total (line 200 minus line 201)	35,858,918	168,462,713			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | 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	950,620	0	950,620	7,101	133.87	30.00
200.00	Total (lines 30-199)	950,620		950,620	7,101		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	3,363	450,205		30.00
200.00	Total (lines 30-199)	3,363	450,205		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/24/2016 11:58 am

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	397,188	20,592,594	0.019288	10,270,846	198,104	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,373	10,457,797	0.000227	1,417,939	322	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,768,559	60,060,460	0.029446	11,469,519	337,731	59.00
60.00	06000	LABORATORY	5,766	12,023,716	0.000480	5,324,632	2,556	60.00
64.00	06400	INTRAVENOUS THERAPY	19,353	1,710,384	0.011315	66,067	748	64.00
65.00	06500	RESPIRATORY THERAPY	1,505	2,870,097	0.000524	1,408,803	738	65.00
66.00	06600	PHYSICAL THERAPY	220	1,493,329	0.000147	900,164	132	66.00
69.00	06900	ELECTROCARDIOLOGY	553,746	20,441,628	0.027089	1,337,142	36,222	69.00
69.01	06901	CARDIAC REHAB	53,590	1,388,873	0.038585	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,333	3,972,107	0.001343	1,393,619	1,872	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,638	20,302,482	0.001411	3,909,993	5,517	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,085	11,915,117	0.000679	4,708,579	3,197	73.00
74.00	07400	RENAL DIALYSIS	10,495	195,814	0.053597	108,590	5,820	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	96,923	1,038,315	0.093346	184,161	17,191	92.00
200.00		Total (lines 50-199)	2,951,774	168,462,713		42,500,054	610,150	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	7,101	0.00	3,363	0		30.00
200.00		Total (lines 30-199)	7,101		3,363	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | 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	20,592,594	0.000000	0.000000	10,270,846	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,457,797	0.000000	0.000000	1,417,939	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	60,060,460	0.000000	0.000000	11,469,519	59.00
60.00	06000	LABORATORY	0	12,023,716	0.000000	0.000000	5,324,632	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,710,384	0.000000	0.000000	66,067	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,870,097	0.000000	0.000000	1,408,803	65.00
66.00	06600	PHYSICAL THERAPY	0	1,493,329	0.000000	0.000000	900,164	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,441,628	0.000000	0.000000	1,337,142	69.00
69.01	06901	CARDIAC REHAB	0	1,388,873	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,972,107	0.000000	0.000000	1,393,619	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,302,482	0.000000	0.000000	3,909,993	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,915,117	0.000000	0.000000	4,708,579	73.00
74.00	07400	RENAL DIALYSIS	0	195,814	0.000000	0.000000	108,590	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,038,315	0.000000	0.000000	184,161	92.00
200.00		Total (lines 50-199)	0	168,462,713			42,500,054	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	339,596	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	862,456	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,155,226	0		59.00
60.00	06000	LABORATORY	0	705,713	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	9,273	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,256	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,597,247	0		69.00
69.01	06901	CARDIAC REHAB	0	644,365	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	292,650	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,518,902	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	968,544	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	177,963	0		92.00
200.00		Total (lines 50-199)	0	26,276,191	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | Hospital | PPS

		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	0.204331	339,596	0	0	69,390	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087002	862,456	0	0	75,035	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.130589	14,155,226	0	10,282	1,848,517	59.00
60.00	06000	LABORATORY	0.183728	705,713	0	0	129,659	60.00
64.00	06400	INTRAVENOUS THERAPY	0.447777	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.200819	9,273	0	0	1,862	65.00
66.00	06600	PHYSICAL THERAPY	0.056715	4,256	0	0	241	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110898	1,597,247	0	382	177,131	69.00
69.01	06901	CARDIAC REHAB	0.599588	644,365	0	0	386,354	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.514077	292,650	0	0	150,445	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.540230	6,518,902	0	0	3,521,706	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259910	968,544	0	34,094	251,734	73.00
74.00	07400	RENAL DIALYSIS	0.283795	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770840	177,963	0	0	137,181	92.00
200.00		Subtotal (see instructions)		26,276,191	0	44,758	6,749,255	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		26,276,191	0	44,758	6,749,255	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | Hospital | PPS

		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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,343		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	42		69.00
69.01	06901	CARDIAC REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,861		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	10,246		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	10,246		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/24/2016 11:58 am

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	950,620	0	950,620	7,101	133.87	30.00
200.00	Total (lines 30-199)	950,620		950,620	7,101		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	129	17,269				30.00
200.00	Total (lines 30-199)	129	17,269				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/24/2016 11:58 am

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	397,188	20,592,594	0.019288	663,041	12,789	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,373	10,457,797	0.000227	96,522	22	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,768,559	60,060,460	0.029446	1,123,274	33,076	59.00
60.00	06000	LABORATORY	5,766	12,023,716	0.000480	501,058	241	60.00
64.00	06400	INTRAVENOUS THERAPY	19,353	1,710,384	0.011315	8,223	93	64.00
65.00	06500	RESPIRATORY THERAPY	1,505	2,870,097	0.000524	185,952	97	65.00
66.00	06600	PHYSICAL THERAPY	220	1,493,329	0.000147	82,488	12	66.00
69.00	06900	ELECTROCARDIOLOGY	553,746	20,441,628	0.027089	125,224	3,392	69.00
69.01	06901	CARDIAC REHAB	53,590	1,388,873	0.038585	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,333	3,972,107	0.001343	144,824	194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,638	20,302,482	0.001411	218,690	309	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,085	11,915,117	0.000679	479,936	326	73.00
74.00	07400	RENAL DIALYSIS	10,495	195,814	0.053597	17,354	930	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	96,923	1,038,315	0.093346	18,986	1,772	92.00
200.00		Total (lines 50-199)	2,951,774	168,462,713		3,665,572	53,253	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/24/2016 11:58 am

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
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	7,101	0.00	129	0		30.00
200.00		Total (lines 30-199)	7,101		129	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 11:58 am

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 11:58 am

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	20,592,594	0.000000	0.000000	663,041	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,457,797	0.000000	0.000000	96,522	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	60,060,460	0.000000	0.000000	1,123,274	59.00
60.00	06000	LABORATORY	0	12,023,716	0.000000	0.000000	501,058	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,710,384	0.000000	0.000000	8,223	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,870,097	0.000000	0.000000	185,952	65.00
66.00	06600	PHYSICAL THERAPY	0	1,493,329	0.000000	0.000000	82,488	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,441,628	0.000000	0.000000	125,224	69.00
69.01	06901	CARDIAC REHAB	0	1,388,873	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,972,107	0.000000	0.000000	144,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,302,482	0.000000	0.000000	218,690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,915,117	0.000000	0.000000	479,936	73.00
74.00	07400	RENAL DIALYSIS	0	195,814	0.000000	0.000000	17,354	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,038,315	0.000000	0.000000	18,986	92.00
200.00		Total (lines 50-199)	0	168,462,713			3,665,572	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 11:58 am

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIAC REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/24/2016 11:58 am

Title XIX | Hospital | PPS

		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	0.204331	0	0	87,023	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087002	0	0	172,670	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.130589	0	0	2,472,068	0	59.00
60.00	06000	LABORATORY	0.183728	0	0	174,192	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.447777	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.200819	0	0	3,064	0	65.00
66.00	06600	PHYSICAL THERAPY	0.056715	0	0	2,660	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110898	0	0	420,752	0	69.00
69.01	06901	CARDIAC REHAB	0.599588	0	0	29,622	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.514077	0	0	57,906	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.540230	0	0	952,675	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259910	0	0	221,310	0	73.00
74.00	07400	RENAL DIALYSIS	0.283795	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770840	0	0	102,606	0	92.00
200.00		Subtotal (see instructions)		0	0	4,696,548	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	4,696,548	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/24/2016 11:58 am

Title XIX | Hospital | PPS

		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	17,781		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,023		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	322,825		59.00
60.00	06000	LABORATORY	0	32,004		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	615		65.00
66.00	06600	PHYSICAL THERAPY	0	151		66.00
69.00	06900	ELECTROCARDIOLOGY	0	46,661		69.00
69.01	06901	CARDIAC REHAB	0	17,761		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,768		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	514,664		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	57,521		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	79,093		92.00
200.00		Subtotal (see instructions)	0	1,133,867		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,133,867		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 11:58 am

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)	7,101	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,101	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)	6,377	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)	3,363	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)	7,850,087	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)	7,850,087	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)	7,850,087	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)	1,105.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,717,763	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)	3,717,763	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	9,479,525	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	13,197,288	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)	450,205	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	610,150	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,060,355	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,136,933	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)	724	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,105.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	800,375	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | 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	950,620	7,850,087	0.121097	800,375	96,923	90.00
91.00	Nursing School cost	0	7,850,087	0.000000	800,375	0	91.00
92.00	Allied health cost	0	7,850,087	0.000000	800,375	0	92.00
93.00	All other Medical Education	0	7,850,087	0.000000	800,375	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 11:58 am

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)	7,101	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,101	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)	6,377	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)	129	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)	7,850,087	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)	7,850,087	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)	7,850,087	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)	1,105.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	142,608	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)	142,608	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 11:58 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	783,463	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	926,071	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)	17,269	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	53,253	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	70,522	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	855,549	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)	724	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,105.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	800,375	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 11:58 am

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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	950,620	7,850,087	0.121097	800,375	96,923	90.00
91.00	Nursing School cost	0	7,850,087	0.000000	800,375	0	91.00
92.00	Allied health cost	0	7,850,087	0.000000	800,375	0	92.00
93.00	All other Medical Education	0	7,850,087	0.000000	800,375	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		6,293,121		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.204331	10,270,846	2,098,652	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087002	1,417,939	123,364	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134384	11,469,519	1,541,320	59.00
60.00	06000	LABORATORY	0.183811	5,324,632	978,726	60.00
64.00	06400	INTRAVENOUS THERAPY	0.447777	66,067	29,583	64.00
65.00	06500	RESPIRATORY THERAPY	0.200819	1,408,803	282,914	65.00
66.00	06600	PHYSICAL THERAPY	0.056715	900,164	51,053	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110898	1,337,142	148,286	69.00
69.01	06901	CARDIAC REHAB	0.599588	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.514077	1,393,619	716,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.540230	3,909,993	2,112,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259910	4,708,579	1,223,807	73.00
74.00	07400	RENAL DIALYSIS	0.286752	108,590	31,138	74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770840	184,161	141,959	92.00
200.00		Total (sum of lines 50-94 and 96-98)		42,500,054	9,479,525	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)		42,500,054		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/24/2016 11:58 am

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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		662,779		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.204331	663,041	135,480	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.087002	96,522	8,398	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.134384	1,123,274	150,950	59.00
60.00	06000	LABORATORY	0.183811	501,058	92,100	60.00
64.00	06400	INTRAVENOUS THERAPY	0.447777	8,223	3,682	64.00
65.00	06500	RESPIRATORY THERAPY	0.200819	185,952	37,343	65.00
66.00	06600	PHYSICAL THERAPY	0.056715	82,488	4,678	66.00
69.00	06900	ELECTROCARDIOLOGY	0.110898	125,224	13,887	69.00
69.01	06901	CARDIAC REHAB	0.599588	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.514077	144,824	74,451	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.540230	218,690	118,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259910	479,936	124,740	73.00
74.00	07400	RENAL DIALYSIS	0.286752	17,354	4,976	74.00
		OUTPATIENT SERVICE COST CENTERS				
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.770840	18,986	14,635	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,665,572	783,463	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,665,572		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/24/2016 11:58 am

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			before 1/1	on/after 1/1		
		0	1.00	1.01	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)		0			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,440,086			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)		155,196			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		22.02			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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/24/2016 11:58 am

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
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)		0.00			30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00			31.00
32.00	Sum of lines 30 and 31		0.00			32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00			33.00
34.00	Disproportionate share adjustment (see instructions)		0			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000009346	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	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	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	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)		11,595,282			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)		11,595,282			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		927,002			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)		12,522,284			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,522,284			61.00
62.00	Deductibles billed to program beneficiaries		815,944			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/24/2016 11:58 am

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		1,846			63.00
64.00	Allowable bad debts (see instructions)		66,000			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		42,900			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		53,551			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,747,394			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)		36,270			70.93
70.94	HRR adjustment amount (see instructions)		-17,160			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,766,504			71.00
71.01	Sequestration adjustment (see instructions)		235,330			71.01
72.00	Interim payments		11,489,131			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)		42,043			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		22,880			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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/24/2016 11:58 am
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		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)			0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/24/2016 11:58 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,440,086	0	0	11,440,086	11,440,086	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	155,196	0	0	155,196	155,196	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,595,282	0	0	11,595,282	11,595,282	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,595,282	0	0	11,595,282	11,595,282	15.00
16.00	Payment for inpatient program capital	50.00	927,002	0	0	927,002	927,002	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/24/2016 11:58 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	0	12,522,284	12,522,284	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	903,523	0	0	903,523	903,523	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	23,479	0	0	23,479	23,479	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	927,002	0	0	927,002	927,002	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.090179		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				1,129,247	1,129,247	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/24/2016 11:58 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,440,086		11,440,086	11,440,086	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	155,196	0	155,196	155,196	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	11,595,282	0	11,595,282	11,595,282	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	11,595,282	0	11,595,282	11,595,282	15.00
16.00	Payment for inpatient program capital	50.00	927,002	0	927,002	927,002	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	12,522,284	12,522,284	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/24/2016 11:58 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	903,523	0	903,523	903,523	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	23,479	0	23,479	23,479	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	927,002	0	927,002	927,002	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	1,129,247		1,129,247	1,129,247	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	36,270	0	36,270	36,270	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-17,160	0	-17,160	-17,160	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/24/2016 11:58 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	10,246	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,749,255	2.00
3.00	PPS payments	7,979,961	3.00
4.00	Outlier payment (see instructions)	152,219	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)	10,246	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	44,758	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)	44,758	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)	44,758	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	34,512	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)	10,246	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)	8,132,180	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)	968,296	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)	7,174,130	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)	7,174,130	30.00
31.00	Primary payer payments	533	31.00
32.00	Subtotal (line 30 minus line 31)	7,173,597	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)	98,959	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	64,323	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	86,455	36.00
37.00	Subtotal (see instructions)	7,237,920	37.00
38.00	MSP-LCC reconciliation amount from PS&R	105	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)	7,237,815	40.00
40.01	Sequestration adjustment (see instructions)	144,756	40.01
41.00	Interim payments	7,021,597	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	71,462	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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2016 11:58 am

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		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		11,489,131		7,021,597	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)		11,489,131		7,021,597	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		42,043		71,462	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,531,174		7,093,059	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: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/24/2016 11:58 am
	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	1,718	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,363	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,146	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	6,377	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	181,162,662	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,408,850	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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/24/2016 11:58 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,229,316	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,500,133	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,672,953	0	0	0	6.00
7.00	Inventory	1,154,077	0	0	0	7.00
8.00	Prepaid expenses	57,497	0	0	0	8.00
9.00	Other current assets	120,625	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)	9,388,695	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	12,598,785	0	0	0	19.00
20.00	Accumulated depreciation	-5,408,139	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)	7,190,646	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	6,823,882	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,823,882	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,403,223	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,116,477	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,390,104	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	445,216	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,957,057	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,908,854	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	7,908,854	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,494,369				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)	15,494,369	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,403,223	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/24/2016 11:58 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,539,519		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,667,296				2.00
3.00	Total (sum of line 1 and line 2)		32,206,815		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		32,206,815		0		11.00
12.00	DISTRIBUTIONS TO MEMBERS	16,712,446		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)		16,712,446		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,494,369		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			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	DISTRIBUTIONS TO MEMBERS		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: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/24/2016 11:58 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,999,897		12,999,897	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)	12,999,897		12,999,897	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,999,897		12,999,897	17.00
18.00	Ancillary services	86,768,549	63,654,038	150,422,587	18.00
19.00	Outpatient services	0	738,367	738,367	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	99,768,446	64,392,405	164,160,851	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45,644,505		29.00
30.00	ROUNDING	6			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)		6		36.00
37.00	GROSS UP FOR CREDITS FOR SERVICES TO	2,964,024			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)		2,964,024		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		42,680,487		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet G-3 Date/Time Prepared: 2/24/2016 11:58 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	164,160,851	1.00
2.00	Less contractual allowances and discounts on patients' accounts	105,175,587	2.00
3.00	Net patient revenues (line 1 minus line 2)	58,985,264	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,680,487	4.00
5.00	Net income from service to patients (line 3 minus line 4)	16,304,777	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	586	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	361,933	24.00
25.00	Total other income (sum of lines 6-24)	362,519	25.00
26.00	Total (line 5 plus line 25)	16,667,296	26.00
27.00		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)	16,667,296	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | Provider CCN: 150175 | Period: From 10/01/2014 To 09/30/2015 | Worksheet I-5 | Date/Time Prepared: 2/24/2016 11:58 am

		1.00	2.00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150175	Period: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prepared: 2/24/2016 11:58 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	903,523	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	23,479	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)	17.47	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)	927,002	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