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: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 7:08 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2016 Time: 7:08 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH WHITE HOSPITAL (151312) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

CHIEF FINANCIAL OFFICER
Title

05/27/2016
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-427,049	-1,309,897	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	-41,354	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-468,403	-1,309,897	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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2016 2:54 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 720 SOUTH SIXTH STREET	PO Box:			1.00
2.00	City: MONTICELLO	State: IN	Zip Code: 47960	County: WHITE	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	IU HEALTH WHITE HOSPITAL	151312	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	IU HEALTH WHITE HOSPITAL	15Z312	99915		02/16/1990	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	2		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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 2:54 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		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.	2		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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 2:54 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 2:54 pm

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2016 2:54 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	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.	N			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:	49,508	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.	N		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: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 2:54 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	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)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/03/2015	12/31/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 2:54 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 2:54 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	C	03/25/2016 4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
				Y/N	Legal Oper.
				1.00	2.00
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N	7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N	8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N	9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N	10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N	11.00
					Y/N
					1.00
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y 12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N 13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N 14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N 15.00
				Part A	Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N 16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/02/2016	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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 2:54 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 2:54 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/02/2016			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.		GOVERNMENT PROGRAMS MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2016 2:54 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	37,920.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	37,920.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	6,240.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	44,160.00	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2016 2:54 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,312	15	1,580			1.00
2.00	HMO and other (see instructions)	182	32				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	423	0	423			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	70			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,735	15	2,073			7.00
8.00	INTENSIVE CARE UNIT	57	4	260			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		0	0			13.00
14.00	Total (see instructions)	1,792	19	2,333	0.00	132.56	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	0	0	0	0.00	0.00	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	132.56	27.00
28.00	Observation Bed Days		12	624			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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2016 2:54 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	411	6	639	1.00
2.00	HMO and other (see instructions)			42	11		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	411	6	639	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/25/2016 2:54 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.336670	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,239,660	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	5,775,804	6.00
7.00	Medicaid cost (line 1 times line 6)	1,944,540	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	861,921	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	5,695,369	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	1,917,460	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)	1,055,539	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)	1,055,539	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	4,471,831	939,364	5,411,195	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,505,531	316,256	1,821,787	21.00
22.00	Partial payment by patients approved for charity care	337	20	357	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,505,194	316,236	1,821,430	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)	2,522,580	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	326,245	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,196,335	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	739,440	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,560,870	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,616,409	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,062,447	2,062,447	-2,050,869	11,578	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	2,741,965	2,741,965	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB		0	0	239,597	239,597	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-29,607	-91,987	-121,594	1,366,178	1,244,584	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	707,518	3,109,703	3,817,221	-73,175	3,744,046	5.00
7.00	00700	OPERATION OF PLANT	182,680	1,201,855	1,384,535	-922,762	461,773	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	0	0	843,197	843,197	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	0	0	245,133	245,133	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	68,174	68,174	8.00
9.00	00900	HOUSEKEEPING	264,510	251,944	516,454	-188,544	327,910	9.00
10.00	01000	DIETARY	455,911	370,219	826,130	-304,615	521,515	10.00
11.00	01100	CAFETERIA	0	0	0	114,806	114,806	11.00
13.00	01300	NURSING ADMINISTRATION	616,071	196,288	812,359	-95,818	716,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106	53,749	53,855	499,662	553,517	14.00
15.00	01500	PHARMACY	321,944	1,302,021	1,623,965	-1,260,844	363,121	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,777	3,777	-3,777	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	807,082	543,391	1,350,473	-290,278	1,060,195	30.00
31.00	03100	INTENSIVE CARE UNIT	146,749	65,533	212,282	-54,838	157,444	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	478,882	903,195	1,382,077	-450,553	931,524	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,427	274,530	583,957	-206,915	377,042	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	57,298	71,515	128,813	-47,420	81,393	55.00
56.00	05600	RADIOISOTOPE	121,539	96,710	218,249	-80,925	137,324	56.00
57.00	05700	CT SCAN	177,015	210,447	387,462	-95,535	291,927	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	99,862	119,605	219,467	-94,334	125,133	58.00
60.00	06000	LABORATORY	0	862,336	862,336	0	862,336	60.00
66.00	06600	PHYSICAL THERAPY	246,221	163,199	409,420	-77,216	332,204	66.00
67.00	06700	OCCUPATIONAL THERAPY	92,154	21,708	113,862	-14,639	99,223	67.00
68.00	06800	SPEECH PATHOLOGY	66,119	18,308	84,427	-13,456	70,971	68.00
69.00	06900	ELECTROCARDIOLOGY	42,909	41,355	84,264	-29,207	55,057	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	16,912	16,912	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	1,219,160	1,219,160	73.00
76.00	03020	CARDIOPULMONARY	348,909	154,058	502,967	-88,685	414,282	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	130,589	86,614	217,203	-36,316	180,887	90.00
91.00	09100	EMERGENCY	1,025,888	1,297,183	2,323,071	-354,158	1,968,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	202,677	25,527	228,204	-10,641	217,563	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,872,453	13,415,230	20,287,683	509,264	20,796,947	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	49,268	59,732	109,000	-27,969	81,031	192.00
192.02	19202	MOB	0	481,292	481,292	-481,292	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	78	9	87	-3	84	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	6,921,799	13,956,263	20,878,062	0	20,878,062	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	168,415	179,993		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	126,398	2,868,363		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	371,819	611,416		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-65,347	1,179,237		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,465,222	7,209,268		5.00
7.00	00700	OPERATION OF PLANT	0	461,773		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	843,197		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	245,133		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,174		8.00
9.00	00900	HOUSEKEEPING	0	327,910		9.00
10.00	01000	DIETARY	-189,392	332,123		10.00
11.00	01100	CAFETERIA	-83,047	31,759		11.00
13.00	01300	NURSING ADMINISTRATION	-225	716,316		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-9,591	543,926		14.00
15.00	01500	PHARMACY	-11,504	351,617		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-127,325	932,870		30.00
31.00	03100	INTENSIVE CARE UNIT	0	157,444		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-365,369	566,155		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,077	373,965		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	81,393		55.00
56.00	05600	RADIOISOTOPE	0	137,324		56.00
57.00	05700	CT SCAN	-83,076	208,851		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	125,133		58.00
60.00	06000	LABORATORY	0	862,336		60.00
66.00	06600	PHYSICAL THERAPY	-7,978	324,226		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	99,223		67.00
68.00	06800	SPEECH PATHOLOGY	0	70,971		68.00
69.00	06900	ELECTROCARDIOLOGY	0	55,057		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,912		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,219,160		73.00
76.00	03020	CARDIOPULMONARY	-1,337	412,945		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-30,000	150,887		90.00
91.00	09100	EMERGENCY	0	1,968,913		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	217,563		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,154,586	23,951,533		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	81,031		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	84		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	3,154,586	24,032,648		200.00

RECLASSIFICATIONS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 2:54 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DEPRECIATION EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,571,360	1.00
2.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	259,671	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	1,831,031	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	80,952	33,854	1.00
	TOTALS		80,952	33,854	
	C - BILLABLE SUPPLIES				
1.00	HOUSEKEEPING	9.00	0	558	1.00
2.00	DIETARY	10.00	0	208	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,616	3.00
4.00	CT SCAN	57.00	0	959	4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16,912	5.00
6.00	CARDIOPULMONARY	76.00	0	379	6.00
7.00	EMERGENCY	91.00	0	3,993	7.00
	TOTALS		0	24,625	
	D - CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	29,151	1.00
2.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1,141,305	2.00
3.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	149	3.00
4.00	MOB	192.02	0	20,074	4.00
	TOTALS		0	1,190,679	
	E - DRUGS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	130	1.00
2.00	NURSING ADMINISTRATION	13.00	0	3	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,219,160	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	1,219,293	
	F - NONBILLABLE SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	527,656	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

RECLASSIFICATIONS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 2:54 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	527,656		
	G - NONBILLABLE DRUGS					
1.00	PHARMACY	15.00	0	3,474		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	TOTALS		0	3,474		
	H - HOUSEKEEPING					
1.00	HOUSEKEEPING	9.00	0	7,182		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	7,182		
	I - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	68,174		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	68,174		
	J - OPERATION OF PLANT COSTS					
1.00	OPERATION OF PLANT - TLMOB	7.02	0	245,133		1.00
2.00	OPERATION OF PLANT - HOSPITAL	7.01	0	843,197		2.00
	TOTALS		0	1,088,330		
	K - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,374,235		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00

RECLASSIFICATIONS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 2:54 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	1,374,235		
	L - NON-CAPITAL COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	97,600		1.00
	TOTALS		0	97,600		
500.00	Grand Total: Increases		80,952	7,466,133		500.00

RECLASSIFICATIONS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 2:54 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	782,813	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	51,133	9		2.00
3.00	OPERATION OF PLANT	7.00	0	11,257	0		3.00
4.00	DIETARY	10.00	0	52,980	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,345	0		5.00
6.00	PHARMACY	15.00	0	29,568	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,777	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	96,314	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	333	0		9.00
10.00	OPERATING ROOM	50.00	0	145,839	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	138,499	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	16,095	0		12.00
13.00	RADIOISOTOPE	56.00	0	54,427	0		13.00
14.00	CT SCAN	57.00	0	28,539	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	72,347	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	4,819	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	133	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	12,175	0		18.00
19.00	CARDIOPULMONARY	76.00	0	1,289	0		19.00
20.00	CLINIC	90.00	0	256	0		20.00
21.00	EMERGENCY	91.00	0	63,325	0		21.00
22.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	96	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,439	0		23.00
24.00	MOB	192.02	0	256,233	0		24.00
	TOTALS		0	1,831,031			
	B - CAFETERIA						
1.00	DIETARY	10.00	80,952	33,854	0		1.00
	TOTALS		80,952	33,854			
	C - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,947	0		1.00
2.00	PHARMACY	15.00	0	436	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	168	0		3.00
4.00	OPERATING ROOM	50.00	0	20,319	0		4.00
5.00	RADIOISOTOPE	56.00	0	178	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	1,577	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		0	24,625			
	D - CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	29,151	12		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,141,305	11		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	149	11		3.00
4.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	20,074	13		4.00
	TOTALS		0	1,190,679			
	E - DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,559	0		1.00
2.00	PHARMACY	15.00	0	1,177,928	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,023	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	1,267	0		4.00
5.00	OPERATING ROOM	50.00	0	1,089	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	440	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	16,947	0		7.00
8.00	RADIOISOTOPE	56.00	0	1,959	0		8.00
9.00	CT SCAN	57.00	0	357	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,728	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	210	0		11.00
12.00	CARDIOPULMONARY	76.00	0	5	0		12.00
13.00	CLINIC	90.00	0	542	0		13.00
14.00	EMERGENCY	91.00	0	6,235	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4	0		15.00
	TOTALS		0	1,219,293			
	F - NONBILLABLE SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	220	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	941	0		2.00
3.00	OPERATION OF PLANT	7.00	0	18,344	0		3.00
4.00	HOUSEKEEPING	9.00	0	26,547	0		4.00
5.00	DIETARY	10.00	0	11	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	483	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	20,702	0		7.00
8.00	PHARMACY	15.00	0	10,675	0		8.00

RECLASSIFICATIONS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 2:54 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
9.00	ADULTS & PEDIATRICS	30.00	0	48,864	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	7,835	0		10.00
11.00	OPERATING ROOM	50.00	0	175,644	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,385	0		12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	838	0		13.00
14.00	RADIOISOTOPE	56.00	0	2,743	0		14.00
15.00	CT SCAN	57.00	0	31,750	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,424	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	9,795	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	215	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	4,572	0		19.00
20.00	CARDIOPULMONARY	76.00	0	13,159	0		20.00
21.00	CLINIC	90.00	0	8,253	0		21.00
22.00	EMERGENCY	91.00	0	125,806	0		22.00
23.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	2,128	0		23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,322	0		24.00
	TOTALS		0	527,656			
	G - NONBILLABLE DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	278	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	584	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	13	0		3.00
4.00	OPERATING ROOM	50.00	0	518	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	256	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	444	0		6.00
7.00	RADIOISOTOPE	56.00	0	16	0		7.00
8.00	CT SCAN	57.00	0	13	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	71	0		9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	28	0		10.00
11.00	CARDIOPULMONARY	76.00	0	9	0		11.00
12.00	CLINIC	90.00	0	341	0		12.00
13.00	EMERGENCY	91.00	0	892	0		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11	0		14.00
	TOTALS		0	3,474			
	H - HOUSEKEEPING						
1.00	DIETARY	10.00	0	6,521	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	111	0		2.00
3.00	PHARMACY	15.00	0	6	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	309	0		4.00
5.00	OPERATING ROOM	50.00	0	70	0		5.00
6.00	SPEECH PATHOLOGY	68.00	0	2	0		6.00
7.00	CLINIC	90.00	0	28	0		7.00
8.00	EMERGENCY	91.00	0	59	0		8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	76	0		9.00
	TOTALS		0	7,182			
	I - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	62,027	0		1.00
2.00	DIETARY	10.00	0	6,147	0		2.00
	TOTALS		0	68,174			
	J - OPERATION OF PLANT COSTS						
1.00	MOB	192.02	0	245,133	0		1.00
2.00	OPERATION OF PLANT	7.00	0	843,197	0		2.00
	TOTALS		0	1,088,330			
	K - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	118,682	0		1.00
2.00	OPERATION OF PLANT	7.00	0	49,964	0		2.00
3.00	HOUSEKEEPING	9.00	0	107,710	0		3.00
4.00	DIETARY	10.00	0	124,358	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	95,227	0		5.00
6.00	PHARMACY	15.00	0	45,705	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	143,800	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	45,222	0		8.00
9.00	OPERATING ROOM	50.00	0	107,074	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	55,335	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	13,096	0		11.00
12.00	RADIOISOTOPE	56.00	0	21,602	0		12.00
13.00	CT SCAN	57.00	0	35,835	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	14,835	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	60,744	0		15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	14,263	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	13,454	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	0	12,460	0		18.00

RECLASSIFICATIONS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 2:54 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
19.00	CARDIOPULMONARY	76.00	0	74,602	0		19.00
20.00	CLINIC	90.00	0	26,896	0		20.00
21.00	EMERGENCY	91.00	0	161,834	0		21.00
22.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	8,417	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	23,117	0		23.00
24.00	OCCUPATIONAL MEDICINE	192.04	0	3	0		24.00
	TOTALS		0	1,374,235			
	L - NON-CAPITAL COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	97,600	9		1.00
	TOTALS		0	97,600			
500.00	Grand Total: Decreases		80,952	7,466,133			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2016 2:54 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	954,570	0	0	0	0	1.00
2.00	Land Improvements	1,982,123	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	31,975,073	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	16,710,045	0	0	0	0	6.00
7.00	HIT designated Assets	557,425	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,179,236	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,179,236	0	0	0	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	954,570	0	1.00
2.00	Land Improvements	1,982,123	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	31,975,073	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	16,710,045	0	6.00
7.00	HIT designated Assets	557,425	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,179,236	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	52,179,236	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2016 2:54 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,062,447	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	0	0	1.02
3.00	Total (sum of lines 1-2)	2,062,447	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	2,062,447	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	1.02
3.00	Total (sum of lines 1-2)	0	2,062,447	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2016 2:54 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: 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	2,062,447	0	2,062,447	0.040236	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	33,413,207	0	33,413,207	0.651851	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	15,783,328	0	15,783,328	0.307913	0	1.02
3.00	Total (sum of lines 1-2)	51,258,982	0	51,258,982	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: 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	1,350,449	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	1,646,946	90,840	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	631,490	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	3,628,885	90,840	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	-1,141,305	-29,151	0	0	179,993	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,101,426	29,151	0	0	2,868,363	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	-20,074	0	611,416	1.02
3.00	Total (sum of lines 1-2)	-39,879	0	-20,074	0	3,659,772	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/25/2016 2:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL (chapter 2)	B	-24,997	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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	-601,671			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	5,434,939			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	*** Cost Center Deleted ***	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	A	168,415	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	-116,509	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - TLMOB	A	371,819	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/25/2016 2:54 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-50,992	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	32.00
33.00	EMPLOYEE BENEFITS	A	-1,222,019	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	INVESTMENT FEES	A	1,287	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	ROUTINE CAPITAL LEASE	A	45,143	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	10	33.02
33.03	DIETARY CAPITAL LEASE	A	45,697	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	10	33.03
33.04	ROUTINE LEASES	A	26,605	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	SURGERY LEASES	A	96,223	OPERATING ROOM	50.00	0	33.05
33.06	LOSS ON ABANDONMENT	A	97,528	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.06
33.07	MARKETING - ADMINISTRATION	A	-120,439	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	CATERING / OTHER REVENUE	B	-18,975	CAFETERIA	11.00	0	33.08
33.09	MEDICAID HAF FEES	A	-509,962	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-16,744	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-64,072	CAFETERIA	11.00	0	33.11
33.12	MISCELLANEOUS INCOME	B	-225	NURSING ADMINISTRATION	13.00	0	33.12
33.13	MISCELLANEOUS INCOME	B	-9,591	CENTRAL SERVICES & SUPPLY	14.00	0	33.13
33.14	MISCELLANEOUS INCOME	B	-11,504	PHARMACY	15.00	0	33.14
33.15	MISCELLANEOUS INCOME	B	-13,120	OPERATING ROOM	50.00	0	33.15
33.16	MISCELLANEOUS INCOME	B	-3,077	RADIOLOGY-DIAGNOSTIC	54.00	0	33.16
33.17	MISCELLANEOUS INCOME	B	-7,978	PHYSICAL THERAPY	66.00	0	33.17
33.18	MISCELLANEOUS INCOME	B	-1,337	CARDIOPULMONARY	76.00	0	33.18
33.19	WIC PROGRAM COSTS	A	-189,392	DIETARY	10.00	0	33.19
33.20	WIC PROGRAM BENEFIT COSTS	A	-36,659	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	CRNA COSTS	A	-113,807	OPERATING ROOM	50.00	0	33.21
33.22			0		0.00	0	33.22
33.23			0		0.00	0	33.23
33.24			0		0.00	0	33.24
33.25			0		0.00	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,154,586				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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2016 2:54 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.01	CAP REL COSTS-BLDG & FIXT -	HO BLDG DEPR ALLOCATION	80,841	0	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	HO ALLOCATION INTEREST EXPEN	1,126,274	1,141,305	2.00
3.00	1.01	CAP REL COSTS-BLDG & FIXT -	MME DEPR	64,718	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	10,839	10,839	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HO ALLOCATION EMPLY BENEFITS	1,193,331	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	COMMUNITY RELATIONS	120,000	120,000	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	245,119	245,119	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	HO ALLOCATION CORPORATE ADMI	2,582,528	1,825,990	4.04
4.05	13.00	NURSING ADMINISTRATION	EMPLOYEE EDUCATION AND TRAIN	36,100	36,100	4.05
4.06	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	8,833	8,833	4.06
4.07	30.00	ADULTS & PEDIATRICS	PHYSICIAN FEES	153,930	153,930	4.07
4.08	57.00	CT SCAN	PHYSICIAN FEES	83,076	83,076	4.08
4.09	60.00	LABORATORY	LAB SERVICES	1,104,066	1,104,066	4.09
4.10	60.00	LABORATORY	LAB MEDICAL DIRECTOR FEES	9,800	9,800	4.10
4.11	76.00	CARDIOPULMONARY	SHARED EMPLOYEES	35,971	35,971	4.11
4.12	192.02	MOB	SHARED EMPLOYEES	25,483	25,483	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	ARNETT ALLOCATIONS	3,354,542	0	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			10,235,451	4,800,512	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	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/25/2016 2:54 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	80,841	9		1.00
2.00	-15,031	11		2.00
3.00	64,718	9		3.00
4.00	0	0		4.00
4.01	1,193,331	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	756,538	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	3,354,542	0		4.13
5.00	5,434,939			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2016 2:54 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	334,665	334,665	0	0	0	1.00
2.00	90.00	CLINIC	30,000	30,000	0	0	0	2.00
3.00	91.00	EMERGENCY	845,723	0	845,723	0	0	3.00
4.00	57.00	CT SCAN	83,076	83,076	0	0	0	4.00
5.00	60.00	LABORATORY	9,800	0	9,800	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	153,930	153,930	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			1,457,194	601,671	855,523		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	57.00	CT SCAN	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	334,665		1.00
2.00	90.00	CLINIC	0	0	0	30,000		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	57.00	CT SCAN	0	0	0	83,076		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	153,930		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	601,671		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/25/2016 2:54 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					29	1.00
2.00	Line 1 multiplied by 15 hours per week					435	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					139	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					4.82	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,055.43	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.52	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.26	39.26	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					82,872	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					82,872	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					82,872	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					82,872	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					5,457	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					5,457	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					670	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					6,127	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					6,127	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					670	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/25/2016 2:54 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	6.26	0.00	0.00	0.00	6.26	47.00
48.00	Overtime rate (see instructions)	117.78	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	737.30	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	1,055.43	0.00	0.00	0.00	1,055.43	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.52	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	82,872	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	737	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	492	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	245	0	0	0	245	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	82,872		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	6,127		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	245		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	89,244		63.00
64.00	Total cost of outside supplier services (from your records)	62,669		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	5,457		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	670		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	6,127		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	670		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	670		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	179,993	179,993				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	2,868,363	0	2,868,363			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	611,416	0	0	611,416		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,179,237	0	0	0	1,179,237	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,209,268	17,901	69,230	143,864	120,023	5.00
7.00	00700	OPERATION OF PLANT	461,773	0	0	0	30,990	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	843,197	6,092	150,909	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	245,133	6,177	0	58,829	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	68,174	607	15,040	0	0	8.00
9.00	00900	HOUSEKEEPING	327,910	3,419	84,702	0	44,871	9.00
10.00	01000	DIETARY	332,123	3,286	0	31,294	63,608	10.00
11.00	01100	CAFETERIA	31,759	1,137	0	10,824	13,733	11.00
13.00	01300	NURSING ADMINISTRATION	716,316	273	0	2,597	104,510	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	543,926	8,148	201,840	0	18	14.00
15.00	01500	PHARMACY	351,617	2,761	68,406	0	54,615	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,704	0	25,754	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	932,870	22,281	551,955	0	136,913	30.00
31.00	03100	INTENSIVE CARE UNIT	157,444	3,051	75,592	0	24,895	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	566,155	16,042	397,397	0	81,238	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	373,965	9,384	232,469	0	52,491	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	81,393	785	19,438	0	9,720	55.00
56.00	05600	RADIOISOTOPE	137,324	696	17,239	0	20,618	56.00
57.00	05700	CT SCAN	208,851	645	15,982	0	30,029	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	125,133	1,579	39,111	0	16,941	58.00
60.00	06000	LABORATORY	862,336	4,481	111,012	0	0	60.00
66.00	06600	PHYSICAL THERAPY	324,226	3,609	89,414	0	41,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,223	330	8,168	0	15,633	67.00
68.00	06800	SPEECH PATHOLOGY	70,971	159	3,927	0	11,216	68.00
69.00	06900	ELECTROCARDIOLOGY	55,057	204	5,066	0	7,279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,912	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	1,219,160	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	412,945	3,189	79,008	0	59,189	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	150,887	2,969	73,550	0	22,153	90.00
91.00	09100	EMERGENCY	1,968,913	13,163	326,085	0	174,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	217,563	9,399	232,823	0	34,382	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,951,533	144,471	2,868,363	273,162	1,170,866	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	81,031	6,854	0	65,275	8,358	192.00
192.02	19202	MOB	0	25,339	0	241,278	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	3,329	0	31,701	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	84	0	0	0	13	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,032,648	179,993	2,868,363	611,416	1,179,237	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,560,286	7,560,286				5.00
7.00	00700	OPERATION OF PLANT	492,763	226,162	718,925			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,000,198	459,059	27,019	1,486,276		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	310,139	142,344	27,399	0	479,882	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	83,821	38,471	2,693	8,441	0	8.00
9.00	00900	HOUSEKEEPING	460,902	211,539	15,165	47,538	0	9.00
10.00	01000	DIETARY	430,311	197,499	14,575	0	36,742	10.00
11.00	01100	CAFETERIA	57,453	26,369	5,041	0	12,708	11.00
13.00	01300	NURSING ADMINISTRATION	823,696	378,050	1,209	0	3,049	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	753,932	346,031	36,138	113,280	0	14.00
15.00	01500	PHARMACY	477,399	219,111	12,248	38,392	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,458	13,061	11,995	0	30,237	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,644,019	754,552	98,825	309,776	0	30.00
31.00	03100	INTENSIVE CARE UNIT	260,982	119,782	13,534	42,425	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,060,832	486,888	71,151	223,033	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	668,309	306,732	41,622	130,470	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	111,336	51,100	3,480	10,909	0	55.00
56.00	05600	RADIOISOTOPE	175,877	80,722	3,087	9,675	0	56.00
57.00	05700	CT SCAN	255,507	117,270	2,862	8,970	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182,764	83,883	7,003	21,951	0	58.00
60.00	06000	LABORATORY	977,829	448,792	19,876	62,304	0	60.00
66.00	06600	PHYSICAL THERAPY	459,018	210,675	16,009	50,182	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,354	56,616	1,462	4,584	0	67.00
68.00	06800	SPEECH PATHOLOGY	86,273	39,597	703	2,204	0	68.00
69.00	06900	ELECTROCARDIOLOGY	67,606	31,029	907	2,843	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,912	7,762	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	1,219,160	559,555	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	554,331	254,420	14,146	44,342	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	249,559	114,540	13,169	41,279	0	90.00
91.00	09100	EMERGENCY	2,482,193	1,139,244	58,384	183,010	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	494,167	226,807	41,685	130,668	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,569,386	7,347,662	561,387	1,486,276	82,736	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	161,518	74,132	30,401	0	76,639	192.00
192.02	19202	MOB	266,617	122,369	112,372	0	283,286	192.02
192.03	19203	ARNETT SURGERY OFFICE	35,030	16,078	14,765	0	37,221	192.03
192.04	19201	OCCUPATIONAL MEDICINE	97	45	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,032,648	7,560,286	718,925	1,486,276	479,882	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	133,426					8.00
9.00	00900	HOUSEKEEPING	1,304	736,448				9.00
10.00	01000	DIETARY	700	31,092	710,919			10.00
11.00	01100	CAFETERIA	239	10,660	0	112,470		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	10,229	1,216,233	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,553	0	0	0	14.00
15.00	01500	PHARMACY	0	29,020	0	4,759	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	47	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,465	124,075	631,691	21,401	396,129	30.00
31.00	03100	INTENSIVE CARE UNIT	5,953	35,238	79,228	2,508	46,413	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,322	90,316	0	10,299	190,617	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,678	26,355	0	7,266	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	203	2,073	0	1,108	0	55.00
56.00	05600	RADIOISOTOPE	1,065	2,073	0	2,111	0	56.00
57.00	05700	CT SCAN	1,627	1,777	0	3,336	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	251	4,442	0	2,251	0	58.00
60.00	06000	LABORATORY	191	42,641	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	2,537	28,131	0	5,622	104,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	497	2,665	0	1,178	0	67.00
68.00	06800	SPEECH PATHOLOGY	120	1,184	0	816	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,085	20,076	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	1,035	26,058	0	8,631	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,011	43,826	0	2,916	0	90.00
91.00	09100	EMERGENCY	55,618	102,753	0	20,586	381,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	610	21,617	0	4,210	77,930	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	133,426	629,549	710,919	110,359	1,216,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,111	0	192.00
192.02	19202	MOB	0	106,899	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	133,426	736,448	710,919	112,470	1,216,233	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	1,252,934					14.00
15.00	01500	PHARMACY	25,564	806,493				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	83,798			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,707	0	41,485	4,178,125	0	30.00
31.00	03100	INTENSIVE CARE UNIT	18,413	0	0	624,476	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	450,868	0	10,044	2,602,370	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,495	0	0	1,213,927	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,928	0	0	182,137	0	55.00
56.00	05600	RADIOISOTOPE	6,721	0	0	281,331	0	56.00
57.00	05700	CT SCAN	70,843	0	0	462,192	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,179	0	0	312,724	0	58.00
60.00	06000	LABORATORY	0	0	0	1,551,633	0	60.00
66.00	06600	PHYSICAL THERAPY	26,165	0	0	902,390	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	0	190,851	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	130,897	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,519	0	0	134,065	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	157,443	0	0	182,117	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	806,493	0	2,585,208	0	73.00
76.00	03020	CARDIOPULMONARY	29,402	0	0	932,365	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,988	0	993	486,281	0	90.00
91.00	09100	EMERGENCY	280,266	0	31,276	4,734,347	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	4,896	0	0	1,002,590	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,249,892	806,493	83,798	22,690,026	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,042	0	0	347,843	0	192.00
192.02	19202	MOB	0	0	0	891,543	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	103,094	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	142	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,252,934	806,493	83,798	24,032,648	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,178,125		30.00
31.00	03100	INTENSIVE CARE UNIT	624,476		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,602,370		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,213,927		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	182,137		55.00
56.00	05600	RADIOISOTOPE	281,331		56.00
57.00	05700	CT SCAN	462,192		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,724		58.00
60.00	06000	LABORATORY	1,551,633		60.00
66.00	06600	PHYSICAL THERAPY	902,390		66.00
67.00	06700	OCCUPATIONAL THERAPY	190,851		67.00
68.00	06800	SPEECH PATHOLOGY	130,897		68.00
69.00	06900	ELECTROCARDIOLOGY	134,065		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,117		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,585,208		73.00
76.00	03020	CARDIOPULMONARY	932,365		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	486,281		90.00
91.00	09100	EMERGENCY	4,734,347		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,002,590		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,690,026		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	347,843		192.00
192.02	19202	MOB	891,543		192.02
192.03	19203	ARNETT SURGERY OFFICE	103,094		192.03
192.04	19201	OCCUPATIONAL MEDICINE	142		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	24,032,648		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	17,901	69,230	143,864	230,995	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	6,092	150,909	0	157,001	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	6,177	0	58,829	65,006	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	607	15,040	0	15,647	8.00
9.00	00900	HOUSEKEEPING	0	3,419	84,702	0	88,121	9.00
10.00	01000	DIETARY	0	3,286	0	31,294	34,580	10.00
11.00	01100	CAFETERIA	0	1,137	0	10,824	11,961	11.00
13.00	01300	NURSING ADMINISTRATION	0	273	0	2,597	2,870	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,148	201,840	0	209,988	14.00
15.00	01500	PHARMACY	0	2,761	68,406	0	71,167	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,704	0	25,754	28,458	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	22,281	551,955	0	574,236	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,051	75,592	0	78,643	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,042	397,397	0	413,439	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,384	232,469	0	241,853	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	785	19,438	0	20,223	55.00
56.00	05600	RADIOISOTOPE	0	696	17,239	0	17,935	56.00
57.00	05700	CT SCAN	0	645	15,982	0	16,627	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,579	39,111	0	40,690	58.00
60.00	06000	LABORATORY	0	4,481	111,012	0	115,493	60.00
66.00	06600	PHYSICAL THERAPY	0	3,609	89,414	0	93,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	330	8,168	0	8,498	67.00
68.00	06800	SPEECH PATHOLOGY	0	159	3,927	0	4,086	68.00
69.00	06900	ELECTROCARDIOLOGY	0	204	5,066	0	5,270	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	0	3,189	79,008	0	82,197	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,969	73,550	0	76,519	90.00
91.00	09100	EMERGENCY	0	13,163	326,085	0	339,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	9,399	232,823	0	242,222	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	144,471	2,868,363	273,162	3,285,996	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,854	0	65,275	72,129	192.00
192.02	19202	MOB	0	25,339	0	241,278	266,617	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	3,329	0	31,701	35,030	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	179,993	2,868,363	611,416	3,659,772	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	230,995				5.00
7.00	00700	OPERATION OF PLANT	0	6,910	6,910			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	14,026	260	171,287		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	4,349	263	0	69,618	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,175	26	973	0	8.00
9.00	00900	HOUSEKEEPING	0	6,463	146	5,479	0	9.00
10.00	01000	DIETARY	0	6,034	140	0	5,330	10.00
11.00	01100	CAFETERIA	0	806	48	0	1,844	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,551	12	0	442	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,572	347	13,055	0	14.00
15.00	01500	PHARMACY	0	6,695	118	4,424	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	399	115	0	4,387	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	23,054	950	35,701	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,660	130	4,889	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,876	684	25,704	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,372	400	15,036	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,561	33	1,257	0	55.00
56.00	05600	RADIOISOTOPE	0	2,466	30	1,115	0	56.00
57.00	05700	CT SCAN	0	3,583	28	1,034	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,563	67	2,530	0	58.00
60.00	06000	LABORATORY	0	13,712	191	7,180	0	60.00
66.00	06600	PHYSICAL THERAPY	0	6,437	154	5,783	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,730	14	528	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,210	7	254	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	948	9	328	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	237	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	17,096	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	0	7,773	136	5,110	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,500	127	4,757	0	90.00
91.00	09100	EMERGENCY	0	34,811	561	21,091	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	6,930	401	15,059	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	224,499	5,397	171,287	12,003	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,265	292	0	11,118	192.00
192.02	19202	MOB	0	3,739	1,079	0	41,097	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	491	142	0	5,400	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	1	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	230,995	6,910	171,287	69,618	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	17,821					8.00
9.00	00900	HOUSEKEEPING	174	100,383				9.00
10.00	01000	DIETARY	93	4,238	50,415			10.00
11.00	01100	CAFETERIA	32	1,453	0	16,144		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,468	16,343	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	484	0	0	0	14.00
15.00	01500	PHARMACY	0	3,956	0	683	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	7	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,340	16,913	44,797	3,072	5,323	30.00
31.00	03100	INTENSIVE CARE UNIT	795	4,803	5,618	360	624	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,111	12,311	0	1,478	2,561	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	625	3,592	0	1,043	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	27	283	0	159	0	55.00
56.00	05600	RADIOISOTOPE	142	283	0	303	0	56.00
57.00	05700	CT SCAN	217	242	0	479	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	34	605	0	323	0	58.00
60.00	06000	LABORATORY	26	5,812	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	339	3,834	0	807	1,398	66.00
67.00	06700	OCCUPATIONAL THERAPY	66	363	0	169	0	67.00
68.00	06800	SPEECH PATHOLOGY	16	161	0	117	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	156	270	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	138	3,552	0	1,239	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	135	5,974	0	419	0	90.00
91.00	09100	EMERGENCY	7,429	14,006	0	2,955	5,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	82	2,947	0	604	1,047	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,821	85,812	50,415	15,841	16,343	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	303	0	192.00
192.02	19202	MOB	0	14,571	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,821	100,383	50,415	16,144	16,343	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	234,446					14.00
15.00	01500	PHARMACY	4,783	91,826				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	33,366			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,341	0	16,519	747,246	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,445	0	0	102,967	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,365	0	3,999	560,528	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,332	0	0	277,253	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	361	0	0	23,904	0	55.00
56.00	05600	RADIOISOTOPE	1,258	0	0	23,532	0	56.00
57.00	05700	CT SCAN	13,256	0	0	35,466	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,905	0	0	48,717	0	58.00
60.00	06000	LABORATORY	0	0	0	142,414	0	60.00
66.00	06600	PHYSICAL THERAPY	4,896	0	0	116,671	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	93	0	0	11,461	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5,851	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,968	0	0	8,949	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,460	0	0	29,697	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	91,826	0	108,922	0	73.00
76.00	03020	CARDIOPULMONARY	5,502	0	0	105,647	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,553	0	395	95,379	0	90.00
91.00	09100	EMERGENCY	52,443	0	12,453	490,117	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	916	0	0	270,208	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	233,877	91,826	33,366	3,204,929	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	569	0	0	86,676	0	192.00
192.02	19202	MOB	0	0	0	327,103	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	41,063	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	1	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	234,446	91,826	33,366	3,659,772	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	747,246		30.00
31.00	03100	INTENSIVE CARE UNIT	102,967		31.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	560,528		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	277,253		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	23,904		55.00
56.00	05600	RADIOISOTOPE	23,532		56.00
57.00	05700	CT SCAN	35,466		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	48,717		58.00
60.00	06000	LABORATORY	142,414		60.00
66.00	06600	PHYSICAL THERAPY	116,671		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,461		67.00
68.00	06800	SPEECH PATHOLOGY	5,851		68.00
69.00	06900	ELECTROCARDIOLOGY	8,949		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,697		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,922		73.00
76.00	03020	CARDIOPULMONARY	105,647		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	95,379		90.00
91.00	09100	EMERGENCY	490,117		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	270,208		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,204,929		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86,676		192.00
192.02	19202	MOB	327,103		192.02
192.03	19203	ARNETT SURGERY OFFICE	41,063		192.03
192.04	19201	OCCUPATIONAL MEDICINE	1		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	3,659,772		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	113,547					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	73,045				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	40,502			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	6,951,406		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,293	1,763	9,530	707,518	-7,560,286	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	182,680	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	3,843	3,843	0	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	3,897	0	3,897	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	383	383	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,157	2,157	0	264,510	0	9.00
10.00	01000	DIETARY	2,073	0	2,073	374,959	0	10.00
11.00	01100	CAFETERIA	717	0	717	80,952	0	11.00
13.00	01300	NURSING ADMINISTRATION	172	0	172	616,071	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,140	5,140	0	106	0	14.00
15.00	01500	PHARMACY	1,742	1,742	0	321,944	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,706	0	1,706	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,056	14,056	0	807,082	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,925	1,925	0	146,749	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,120	10,120	0	478,882	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,920	5,920	0	309,427	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	495	495	0	57,298	0	55.00
56.00	05600	RADIOISOTOPE	439	439	0	121,539	0	56.00
57.00	05700	CT SCAN	407	407	0	177,015	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	996	996	0	99,862	0	58.00
60.00	06000	LABORATORY	2,827	2,827	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	2,277	2,277	0	246,221	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	208	208	0	92,154	0	67.00
68.00	06800	SPEECH PATHOLOGY	100	100	0	66,119	0	68.00
69.00	06900	ELECTROCARDIOLOGY	129	129	0	42,909	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	2,012	2,012	0	348,909	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,873	1,873	0	130,589	0	90.00
91.00	09100	EMERGENCY	8,304	8,304	0	1,025,888	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	5,929	5,929	0	202,677	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	91,140	73,045	18,095	6,902,060	-7,560,286	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,324	0	4,324	49,268	0	192.00
192.02	19202	MOB	15,983	0	15,983	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	2,100	0	2,100	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	78	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	179,993	2,868,363	611,416	1,179,237		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.585185	39.268437	15.095946	0.169640		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TLMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,472,362					5.00
7.00	00700	OPERATION OF PLANT	492,763	102,254				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	1,000,198	3,843	67,439			7.01
7.02	00702	OPERATION OF PLANT - TLMOB	310,139	3,897	0	27,075		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	83,821	383	383	0	22,303	8.00
9.00	00900	HOUSEKEEPING	460,902	2,157	2,157	0	218	9.00
10.00	01000	DIETARY	430,311	2,073	0	2,073	117	10.00
11.00	01100	CAFETERIA	57,453	717	0	717	40	11.00
13.00	01300	NURSING ADMINISTRATION	823,696	172	0	172	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	753,932	5,140	5,140	0	0	14.00
15.00	01500	PHARMACY	477,399	1,742	1,742	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,458	1,706	0	1,706	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,644,019	14,056	14,056	0	7,934	30.00
31.00	03100	INTENSIVE CARE UNIT	260,982	1,925	1,925	0	995	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,060,832	10,120	10,120	0	1,391	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	668,309	5,920	5,920	0	782	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	111,336	495	495	0	34	55.00
56.00	05600	RADIOISOTOPE	175,877	439	439	0	178	56.00
57.00	05700	CT SCAN	255,507	407	407	0	272	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182,764	996	996	0	42	58.00
60.00	06000	LABORATORY	977,829	2,827	2,827	0	32	60.00
66.00	06600	PHYSICAL THERAPY	459,018	2,277	2,277	0	424	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,354	208	208	0	83	67.00
68.00	06800	SPEECH PATHOLOGY	86,273	100	100	0	20	68.00
69.00	06900	ELECTROCARDIOLOGY	67,606	129	129	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,912	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	1,219,160	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	554,331	2,012	2,012	0	173	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	249,559	1,873	1,873	0	169	90.00
91.00	09100	EMERGENCY	2,482,193	8,304	8,304	0	9,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	494,167	5,929	5,929	0	102	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,009,100	79,847	67,439	4,668	22,303	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	161,518	4,324	0	4,324	0	192.00
192.02	19202	MOB	266,617	15,983	0	15,983	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	35,030	2,100	0	2,100	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	97	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,560,286	718,925	1,486,276	479,882	133,426	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.458968	7.030776	22.038820	17.724174	5.982424	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	230,995	6,910	171,287	69,618	17,821	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.014023	0.067577	2.539880	2.571302	0.799040	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,487					9.00
10.00	01000	DIETARY	105	2,333				10.00
11.00	01100	CAFETERIA	36	0	9,643			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	877	5,634		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12	0	0	0	544,568	14.00
15.00	01500	PHARMACY	98	0	408	0	11,111	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	419	2,073	1,835	1,835	47,248	30.00
31.00	03100	INTENSIVE CARE UNIT	119	260	215	215	8,003	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	305	0	883	883	195,963	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89	0	623	0	12,385	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7	0	95	0	838	55.00
56.00	05600	RADIOISOTOPE	7	0	181	0	2,921	56.00
57.00	05700	CT SCAN	6	0	286	0	30,791	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15	0	193	0	4,424	58.00
60.00	06000	LABORATORY	144	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	95	0	482	482	11,372	66.00
67.00	06700	OCCUPATIONAL THERAPY	9	0	101	0	215	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	70	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	93	93	4,572	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	68,430	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	88	0	740	0	12,779	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	148	0	250	0	8,253	90.00
91.00	09100	EMERGENCY	347	0	1,765	1,765	121,813	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	73	0	361	361	2,128	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,126	2,333	9,462	5,634	543,246	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	181	0	1,322	192.00
192.02	19202	MOB	361	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	736,448	710,919	112,470	1,216,233	1,252,934	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	296.119019	304.723103	11.663383	215.873802	2.300785	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	100,383	50,415	16,144	16,343	234,446	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	40.363088	21.609516	1.674168	2.900781	0.430517	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 2:54 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB				1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - TLMOB				7.02
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	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,237		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	22,395		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,422		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0		73.00
76.00	03020	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	536		90.00
91.00	09100	EMERGENCY	0	16,884		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	45,237		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.02	19202	MOB	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19201	OCCUPATIONAL MEDICINE	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	806,493	83,798		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8,064.930000	1.852422		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	91,826	33,366		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	918.260000	0.737582		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,178,125		4,178,125	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	624,476		624,476	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,602,370		2,602,370	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,213,927		1,213,927	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	182,137		182,137	0	0	55.00
56.00	05600	RADIOISOTOPE	281,331		281,331	0	0	56.00
57.00	05700	CT SCAN	462,192		462,192	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,724		312,724	0	0	58.00
60.00	06000	LABORATORY	1,551,633		1,551,633	0	0	60.00
66.00	06600	PHYSICAL THERAPY	902,390	0	902,390	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	190,851	0	190,851	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	130,897	0	130,897	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	134,065		134,065	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,117		182,117	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,585,208		2,585,208	0	0	73.00
76.00	03020	CARDIOPULMONARY	932,365		932,365	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	486,281		486,281	0	0	90.00
91.00	09100	EMERGENCY	4,734,347		4,734,347	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	990,213		990,213		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,002,590		1,002,590	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	23,680,239	0	23,680,239	0	0	200.00
201.00		Less Observation Beds	990,213		990,213		0	201.00
202.00		Total (see instructions)	22,690,026	0	22,690,026	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,556,220		2,556,220			30.00
31.00	03100	INTENSIVE CARE UNIT	341,633		341,633			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	140,354	6,850,115	6,990,469	0.372274	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	138,851	5,049,402	5,188,253	0.233976	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	34,409	817,205	851,614	0.213873	0.000000	55.00
56.00	05600	RADIOISOTOPE	356,752	3,047,066	3,403,818	0.082652	0.000000	56.00
57.00	05700	CT SCAN	392,045	4,205,425	4,597,470	0.100532	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	79,643	784,300	863,943	0.361973	0.000000	58.00
60.00	06000	LABORATORY	1,578,178	5,987,012	7,565,190	0.205102	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	401,992	831,777	1,233,769	0.731409	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	148,087	132,861	280,948	0.679311	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	21,380	113,538	134,918	0.970197	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	96,722	2,509,134	2,605,856	0.051448	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,744	505,782	530,526	0.343276	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,713,358	6,930,365	8,643,723	0.299085	0.000000	73.00
76.00	03020	CARDIOPULMONARY	495,088	381,900	876,988	1.063145	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	615	760,644	761,259	0.638785	0.000000	90.00
91.00	09100	EMERGENCY	195,815	14,325,497	14,521,312	0.326027	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,328	2,465,369	2,478,697	0.399489	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	192,311	2,776,567	2,968,878	0.337700	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	8,921,525	58,473,959	67,395,484			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,921,525	58,473,959	67,395,484			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIOPULMONARY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 2:54 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,178,125		4,178,125	0	4,178,125	30.00
31.00	03100	INTENSIVE CARE UNIT	624,476		624,476	0	624,476	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,602,370		2,602,370	0	2,602,370	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,213,927		1,213,927	0	1,213,927	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	182,137		182,137	0	182,137	55.00
56.00	05600	RADIOISOTOPE	281,331		281,331	0	281,331	56.00
57.00	05700	CT SCAN	462,192		462,192	0	462,192	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	312,724		312,724	0	312,724	58.00
60.00	06000	LABORATORY	1,551,633		1,551,633	0	1,551,633	60.00
66.00	06600	PHYSICAL THERAPY	902,390	0	902,390	0	902,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	190,851	0	190,851	0	190,851	67.00
68.00	06800	SPEECH PATHOLOGY	130,897	0	130,897	0	130,897	68.00
69.00	06900	ELECTROCARDIOLOGY	134,065		134,065	0	134,065	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,117		182,117	0	182,117	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,585,208		2,585,208	0	2,585,208	73.00
76.00	03020	CARDIOPULMONARY	932,365		932,365	0	932,365	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	486,281		486,281	0	486,281	90.00
91.00	09100	EMERGENCY	4,734,347		4,734,347	0	4,734,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	990,213		990,213		990,213	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,002,590		1,002,590	0	1,002,590	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	23,680,239	0	23,680,239	0	23,680,239	200.00
201.00		Less Observation Beds	990,213		990,213		990,213	201.00
202.00		Total (see instructions)	22,690,026	0	22,690,026	0	22,690,026	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 2:54 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,556,220		2,556,220			30.00
31.00	03100	INTENSIVE CARE UNIT	341,633		341,633			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	140,354	6,850,115	6,990,469	0.372274	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	138,851	5,049,402	5,188,253	0.233976	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	34,409	817,205	851,614	0.213873	0.000000	55.00
56.00	05600	RADIOISOTOPE	356,752	3,047,066	3,403,818	0.082652	0.000000	56.00
57.00	05700	CT SCAN	392,045	4,205,425	4,597,470	0.100532	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	79,643	784,300	863,943	0.361973	0.000000	58.00
60.00	06000	LABORATORY	1,578,178	5,987,012	7,565,190	0.205102	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	401,992	831,777	1,233,769	0.731409	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	148,087	132,861	280,948	0.679311	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	21,380	113,538	134,918	0.970197	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	96,722	2,509,134	2,605,856	0.051448	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,744	505,782	530,526	0.343276	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,713,358	6,930,365	8,643,723	0.299085	0.000000	73.00
76.00	03020	CARDIOPULMONARY	495,088	381,900	876,988	1.063145	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	615	760,644	761,259	0.638785	0.000000	90.00
91.00	09100	EMERGENCY	195,815	14,325,497	14,521,312	0.326027	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,328	2,465,369	2,478,697	0.399489	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	192,311	2,776,567	2,968,878	0.337700	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	8,921,525	58,473,959	67,395,484			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,921,525	58,473,959	67,395,484			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 2:54 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIOPULMONARY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	560,528	6,990,469	0.080185	81,630	6,546	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	277,253	5,188,253	0.053439	86,771	4,637	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	23,904	851,614	0.028069	13,887	390	55.00
56.00	05600	RADIOISOTOPE	23,532	3,403,818	0.006913	190,232	1,315	56.00
57.00	05700	CT SCAN	35,466	4,597,470	0.007714	196,546	1,516	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	48,717	863,943	0.056389	56,780	3,202	58.00
60.00	06000	LABORATORY	142,414	7,565,190	0.018825	974,413	18,343	60.00
66.00	06600	PHYSICAL THERAPY	116,671	1,233,769	0.094565	194,909	18,432	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,461	280,948	0.040794	64,541	2,633	67.00
68.00	06800	SPEECH PATHOLOGY	5,851	134,918	0.043367	11,809	512	68.00
69.00	06900	ELECTROCARDIOLOGY	8,949	2,605,856	0.003434	51,233	176	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,697	530,526	0.055977	16,942	948	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,922	8,643,723	0.012601	985,704	12,421	73.00
76.00	03020	CARDIOPULMONARY	105,647	876,988	0.120466	308,124	37,118	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	95,379	761,259	0.125291	156	20	90.00
91.00	09100	EMERGENCY	490,117	14,521,312	0.033752	6,718	227	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	211,561	2,478,697	0.085352	294	25	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	270,208	2,968,878	0.091014	8,852	806	92.01
200.00		Total (lines 50-199)	2,566,277	64,497,631		3,249,541	109,267	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,990,469	0.000000	0.000000	81,630	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,188,253	0.000000	0.000000	86,771	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	851,614	0.000000	0.000000	13,887	55.00
56.00	05600	RADIOISOTOPE	0	3,403,818	0.000000	0.000000	190,232	56.00
57.00	05700	CT SCAN	0	4,597,470	0.000000	0.000000	196,546	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	863,943	0.000000	0.000000	56,780	58.00
60.00	06000	LABORATORY	0	7,565,190	0.000000	0.000000	974,413	60.00
66.00	06600	PHYSICAL THERAPY	0	1,233,769	0.000000	0.000000	194,909	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	280,948	0.000000	0.000000	64,541	67.00
68.00	06800	SPEECH PATHOLOGY	0	134,918	0.000000	0.000000	11,809	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,605,856	0.000000	0.000000	51,233	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	530,526	0.000000	0.000000	16,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,643,723	0.000000	0.000000	985,704	73.00
76.00	03020	CARDIOPULMONARY	0	876,988	0.000000	0.000000	308,124	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	761,259	0.000000	0.000000	156	90.00
91.00	09100	EMERGENCY	0	14,521,312	0.000000	0.000000	6,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,478,697	0.000000	0.000000	294	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2,968,878	0.000000	0.000000	8,852	92.01
200.00		Total (lines 50-199)	0	64,497,631			3,249,541	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIOPULMONARY	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.372274	0	2,245,418	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233976	0	1,541,773	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.213873	0	375,825	0	0	55.00
56.00	05600	RADIOISOTOPE	0.082652	0	1,137,184	0	0	56.00
57.00	05700	CT SCAN	0.100532	0	1,436,782	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.361973	0	296,734	0	0	58.00
60.00	06000	LABORATORY	0.205102	0	2,227,377	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.731409	0	341,757	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.679311	0	40,056	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.970197	0	20,281	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051448	0	1,029,323	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343276	0	122,896	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299085	0	3,477,255	4,777	0	73.00
76.00	03020	CARDIOPULMONARY	1.063145	0	178,675	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.638785	0	395,017	2,171	0	90.00
91.00	09100	EMERGENCY	0.326027	0	3,960,856	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.399489	0	1,244,359	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.337700	0	1,256,586	0	0	92.01
200.00		Subtotal (see instructions)		0	21,328,154	6,948	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	21,328,154	6,948	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	835,911	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	360,738	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	80,379	0		55.00
56.00	05600	RADIOISOTOPE	93,991	0		56.00
57.00	05700	CT SCAN	144,443	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	107,410	0		58.00
60.00	06000	LABORATORY	456,839	0		60.00
66.00	06600	PHYSICAL THERAPY	249,964	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	27,210	0		67.00
68.00	06800	SPEECH PATHOLOGY	19,677	0		68.00
69.00	06900	ELECTROCARDIOLOGY	52,957	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,187	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,039,995	1,429		73.00
76.00	03020	CARDIOPULMONARY	189,957	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	252,331	1,387		90.00
91.00	09100	EMERGENCY	1,291,346	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	497,108	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	424,349	0		92.01
200.00		Subtotal (see instructions)	6,166,792	2,816		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,166,792	2,816		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151312 | Component CCN: 15Z312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.372274	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233976	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.213873	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.082652	0	0	0	0	56.00
57.00	05700	CT SCAN	0.100532	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.361973	0	0	0	0	58.00
60.00	06000	LABORATORY	0.205102	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.731409	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.679311	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.970197	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051448	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343276	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299085	0	0	0	0	73.00
76.00	03020	CARDIOPULMONARY	1.063145	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.638785	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.326027	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.399489	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.337700	0	0	0	0	92.01
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151312 | Component CCN: 15Z312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	CARDIOPULMONARY	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 2:54 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.372274	0	50,810	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233976	0	112,728	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.213873	0	8,376	0	0	55.00
56.00	05600	RADIOISOTOPE	0.082652	0	77,178	0	0	56.00
57.00	05700	CT SCAN	0.100532	0	91,768	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.361973	0	19,932	0	0	58.00
60.00	06000	LABORATORY	0.205102	0	172,844	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.731409	0	36,943	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.679311	0	4,330	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.970197	0	13,227	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051448	0	46,228	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343276	0	10,555	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299085	0	66,957	0	0	73.00
76.00	03020	CARDIOPULMONARY	1.063145	0	11,745	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.638785	0	1,255	0	0	90.00
91.00	09100	EMERGENCY	0.326027	0	530,736	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.399489	0	14,372	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.337700	0	67,079	0	0	92.01
200.00		Subtotal (see instructions)		0	1,337,063	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	1,337,063	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 2:54 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	18,915	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,376	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,791	0		55.00
56.00	05600	RADIOISOTOPE	6,379	0		56.00
57.00	05700	CT SCAN	9,226	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,215	0		58.00
60.00	06000	LABORATORY	35,451	0		60.00
66.00	06600	PHYSICAL THERAPY	27,020	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,941	0		67.00
68.00	06800	SPEECH PATHOLOGY	12,833	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,378	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,623	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,026	0		73.00
76.00	03020	CARDIOPULMONARY	12,487	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	802	0		90.00
91.00	09100	EMERGENCY	173,034	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,741	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	22,653	0		92.01
200.00		Subtotal (see instructions)	388,891	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	388,891	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,697	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,204	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,580	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	423	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	70	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,312	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)	423	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.09	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)	4,178,125	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)	9,386	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)	680,636	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,497,489	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,497,489	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)	1,586.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,081,987	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,081,987	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	624,476	260	2,401.83	57	136,904	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,143,645	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,362,536	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	671,250	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)	671,250	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)	624	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,586.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	990,213	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	747,246	3,497,489	0.213652	990,213	211,561	90.00
91.00	Nursing School cost	0	3,497,489	0.000000	990,213	0	91.00
92.00	Allied health cost	0	3,497,489	0.000000	990,213	0	92.00
93.00	All other Medical Education	0	3,497,489	0.000000	990,213	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 2:54 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,697	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,204	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,580	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	423	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	70	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)	15	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.09	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)	4,178,125	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)	9,386	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)	680,636	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,497,489	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,497,489	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)	1,586.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	23,803	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)	23,803	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 2:54 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	624,476	260	2,401.83	4	9,607	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)	17,913	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	51,323	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	624	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,586.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	990,213	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 2:54 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	747,246	3,497,489	0.213652	990,213	211,561	90.00
91.00	Nursing School cost	0	3,497,489	0.000000	990,213	0	91.00
92.00	Allied health cost	0	3,497,489	0.000000	990,213	0	92.00
93.00	All other Medical Education	0	3,497,489	0.000000	990,213	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,784,427		30.00
31.00	03100	INTENSIVE CARE UNIT		178,737		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.372274	81,630	30,389	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233976	86,771	20,302	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.213873	13,887	2,970	55.00
56.00	05600	RADIOISOTOPE	0.082652	190,232	15,723	56.00
57.00	05700	CT SCAN	0.100532	196,546	19,759	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.361973	56,780	20,553	58.00
60.00	06000	LABORATORY	0.205102	974,413	199,854	60.00
66.00	06600	PHYSICAL THERAPY	0.731409	194,909	142,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.679311	64,541	43,843	67.00
68.00	06800	SPEECH PATHOLOGY	0.970197	11,809	11,457	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051448	51,233	2,636	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343276	16,942	5,816	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299085	985,704	294,809	73.00
76.00	03020	CARDIOPULMONARY	1.063145	308,124	327,580	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.638785	156	100	90.00
91.00	09100	EMERGENCY	0.326027	6,718	2,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.399489	294	117	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.337700	8,852	2,989	92.01
200.00		Total (sum of lines 50-94 and 96-98)		3,249,541	1,143,645	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)		3,249,541		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3

Component CCN: 15Z312 | Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.372274	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233976	9,719	2,274	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.213873	2,847	609	55.00
56.00	05600	RADIOISOTOPE	0.082652	10,493	867	56.00
57.00	05700	CT SCAN	0.100532	8,874	892	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.361973	0	0	58.00
60.00	06000	LABORATORY	0.205102	118,630	24,331	60.00
66.00	06600	PHYSICAL THERAPY	0.731409	141,726	103,660	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.679311	57,398	38,991	67.00
68.00	06800	SPEECH PATHOLOGY	0.970197	5,396	5,235	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051448	3,518	181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343276	530	182	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299085	245,598	73,455	73.00
76.00	03020	CARDIOPULMONARY	1.063145	90,469	96,182	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.638785	305	195	90.00
91.00	09100	EMERGENCY	0.326027	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.399489	1,224	489	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.337700	0	0	92.01
200.00		Total (sum of lines 50-94 and 96-98)		696,727	347,543	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)		696,727		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/25/2016 2:54 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		16,415		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.372274	2,404	895	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.233976	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.213873	0	0	55.00
56.00	05600	RADIOISOTOPE	0.082652	4,194	347	56.00
57.00	05700	CT SCAN	0.100532	9,217	927	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.361973	0	0	58.00
60.00	06000	LABORATORY	0.205102	14,060	2,884	60.00
66.00	06600	PHYSICAL THERAPY	0.731409	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.679311	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.970197	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051448	1,008	52	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343276	318	109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299085	11,898	3,559	73.00
76.00	03020	CARDIOPULMONARY	1.063145	4,321	4,594	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.638785	0	0	90.00
91.00	09100	EMERGENCY	0.326027	13,875	4,524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.399489	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.337700	66	22	92.01
200.00		Total (sum of lines 50-94 and 96-98)		61,361	17,913	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)		61,361		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 2:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,169,608	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,169,608	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6,231,304	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	36,687	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,817,177	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,377,440	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,377,440	30.00
31.00	Primary payer payments	2,022	31.00
32.00	Subtotal (line 30 minus line 31)	2,375,418	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)	469,181	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	304,968	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	414,387	36.00
37.00	Subtotal (see instructions)	2,680,386	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,680,386	40.00
40.01	Sequestration adjustment (see instructions)	53,608	40.01
41.00	Interim payments	3,936,675	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-1,309,897	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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I Date/Time Prepared: 5/25/2016 2:54 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,021,942		3,936,675	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/22/2015	398,500		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)		398,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,420,442		3,936,675	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		427,049		1,309,897	6.02
7.00	Total Medicare program liability (see instructions)		2,993,393		2,626,778	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2016 2:54 pm

Component CCN: 15Z312 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		907,972		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/22/2015	133,700		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)		133,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,041,672		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		41,354		0	6.02
7.00	Total Medicare program liability (see instructions)		1,000,318		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/25/2016 2:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	639	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,369	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	182	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,840	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	67,395,484	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	5,411,195	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151312 Component CCN: 15Z312	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 5/25/2016 2:54 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	677,963	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	351,018	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	423	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,028,981	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,028,981	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,028,981	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,135	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,019,846	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	1,365	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	887	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,365	0	18.00
19.00	Total (see instructions)	1,020,733	0	19.00
19.01	Sequestration adjustment (see instructions)	20,415	0	19.01
20.00	Interim payments	1,041,672	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-41,354	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/25/2016 2:54 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,362,536	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,362,536	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,396,161	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,396,161	19.00
20.00	Deductibles (exclude professional component)	357,658	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,038,503	22.00
23.00	Coinsurance	4,410	23.00
24.00	Subtotal (line 22 minus line 23)	3,034,093	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,369	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,390	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	25,171	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,054,483	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,054,483	30.00
30.01	Sequestration adjustment (see instructions)	61,090	30.01
31.00	Interim payments	3,420,442	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-427,049	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/25/2016 2:54 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	18,441,140	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	2,334,885	0	0	0	4.00
5.00	Other receivable	513,742	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	278,446	0	0	0	7.00
8.00	Prepaid expenses	103,442	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	21,671,655	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	972,779	0	0	0	12.00
13.00	Land improvements	149,251	0	0	0	13.00
14.00	Accumulated depreciation	-77,350	0	0	0	14.00
15.00	Buildings	30,187,561	0	0	0	15.00
16.00	Accumulated depreciation	-3,263,949	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	1,773,122	0	0	0	19.00
20.00	Accumulated depreciation	-767,318	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	5,254,949	0	0	0	23.00
24.00	Accumulated depreciation	-2,746,143	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)	31,482,902	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,370,666	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,370,666	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	54,525,223	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,161,835	0	0	0	37.00
38.00	Salaries, wages, and fees payable	735,093	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	535,684	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	5,589,693	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,022,305	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	960	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	22,120,496	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	22,121,456	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	30,143,761	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	24,381,462				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)	24,381,462	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	54,525,223	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/25/2016 2:54 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		15,946,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,352,154				2.00
3.00	Total (sum of line 1 and line 2)		24,298,154		0		3.00
4.00	RECONCILING ITEM	83,308		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)		83,308		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,381,462		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,381,462		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	RECONCILING ITEM		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			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: 151312 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/25/2016 2:54 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,556,220		2,556,220	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,556,220		2,556,220	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	341,633		341,633	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)	341,633		341,633	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,897,853		2,897,853	17.00
18.00	Ancillary services	5,817,419	38,145,883	43,963,302	18.00
19.00	Outpatient services	206,253	20,328,077	20,534,330	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN CHARGES	0	395,068	395,068	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,921,525	58,869,028	67,790,553	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,878,062		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,878,062		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151312	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/25/2016 2:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67,790,553	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,435,162	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,355,391	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,878,062	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,477,329	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	TOTAL OTHER INCOME	874,825	24.00
25.00	Total other income (sum of lines 6-24)	874,825	25.00
26.00	Total (line 5 plus line 25)	8,352,154	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,352,154	29.00