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: 151326	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/25/2016 10:53 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2016 Time: 10:53 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 UNION HOSPITAL CLINTON (151326) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/25/2016 Time: 10:53 am
O8FBXOY1Jfy7jK.Vn8BcgjrIigAn50
ABeAOORtiqmOYiIxOdJ5E9RqvMWOQZ
B:YNO9yPEpOptLke

PI: Date: 5/25/2016 Time: 10:53 am
dWXjDoyEegQgA6:IOqIpPVO18wKl3O
QP.3oOQpg4MN.U5OQ5hxWL5cIu9ylY
NmZFOmEz2tOzX9:8

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

President + CEO
Title

5/27/16
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-219,418	45,511	19,184	593,353	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	40,351	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-179,067	45,511	19,184	593,353	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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2016 10:53 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: CLINTON	State: IN	Zip Code: 47842-	County: VERMILLION	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	UNION HOSPITAL CLINTON	151326	45460	1	03/01/2005	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	SWING BEDS	15Z326	45460		03/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 10:53 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 10:53 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 10:53 am

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

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	144,152	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: 151326	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 10:53 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H043	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: UNION HOSPITAL, INC.	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1606 NORTH SEVENTH ST	PO Box:		142.00
143.00	City: TERRE HAUTE	State: IN	Zip Code: 47804	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	23,107	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)	N	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)	09/01/2014	12/31/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151326	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 10:53 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 10:53 am

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

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	03/30/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 10:53 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CAROLYN	CHAPLIN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3177137919	CCHAPLIN@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2016 10:53 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	03/30/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2016 10:53 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	19	6,935	41,736.00	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)		19	6,935	41,736.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	12,384.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	54,120.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2016 10:53 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,095	197	1,739			1.00
2.00	HMO and other (see instructions)	75	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	116	0	116			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	6			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,211	197	1,861			7.00
8.00	INTENSIVE CARE UNIT	242	116	516			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,453	313	2,377	0.00	135.09	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	135.09	27.00
28.00	Observation Bed Days		0	954			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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2016 10:53 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	499	159	752	1.00
2.00	HMO and other (see instructions)			27	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	499	159	752	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151326	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/25/2016 10:53 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.294749	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	0	6.00
7.00	Medicaid cost (line 1 times line 6)	0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,291,965	0	2,291,965	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	675,554	0	675,554	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	675,554	0	675,554	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,239,325	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	655,101	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,584,224	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	761,697	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,437,251	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,437,251	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		776,074	776,074	0	776,074	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		302,763	302,763	0	302,763	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	36,151	36,151	0	36,151	5.01
5.02	00550	DATA PROCESSING	0	858,577	858,577	0	858,577	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	7,909	7,909	0	7,909	5.03
5.04	00570	ADMITTING	456,985	62,123	519,108	0	519,108	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	22,328	369,234	391,562	0	391,562	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	647,462	948,976	1,596,438	0	1,596,438	5.06
7.00	00700	OPERATION OF PLANT	372,051	602,486	974,537	0	974,537	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,058	2,058	0	2,058	8.00
9.00	00900	HOUSEKEEPING	222,126	87,661	309,787	0	309,787	9.00
10.00	01000	DIETARY	312,480	236,892	549,372	-423,747	125,625	10.00
11.00	01100	CAFETERIA	0	0	0	423,747	423,747	11.00
13.00	01300	NURSING ADMINISTRATION	554,278	100,674	654,952	0	654,952	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	179,792	93,683	273,475	0	273,475	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,322,946	326,163	1,649,109	0	1,649,109	30.00
31.00	03100	INTENSIVE CARE UNIT	655,694	94,729	750,423	0	750,423	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	288,426	784,853	1,073,279	0	1,073,279	50.00
51.00	05100	RECOVERY ROOM	74,811	5,669	80,480	0	80,480	51.00
51.01	05101	O/P TREATMENT ROOM	148,633	34,866	183,499	0	183,499	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	831,398	672,155	1,503,553	0	1,503,553	54.00
56.00	05600	RADIOISOTOPE	0	112,795	112,795	0	112,795	56.00
60.00	06000	LABORATORY	0	967,042	967,042	0	967,042	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	60,638	60,638	0	60,638	62.00
65.00	06500	RESPIRATORY THERAPY	328,918	119,411	448,329	0	448,329	65.00
66.00	06600	PHYSICAL THERAPY	0	991,057	991,057	0	991,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,991	6,991	0	6,991	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,060	25,060	0	25,060	68.00
69.00	06900	ELECTROCARDIOLOGY	102,233	63,284	165,517	0	165,517	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	80,899	80,899	0	80,899	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,424	738,400	1,128,824	0	1,128,824	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	588	588	0	588	90.00
91.00	09100	EMERGENCY	1,088,668	303,379	1,392,047	0	1,392,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,999,653	9,873,240	17,872,893	0	17,872,893	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	191,629	283,232	474,861	0	474,861	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	8,191,282	10,156,472	18,347,754	0	18,347,754	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	649,977	1,426,051		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	302,763		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,461,480	1,461,480		4.00
5.01	00540	NONPATIENT TELEPHONES	32,403	68,554		5.01
5.02	00550	DATA PROCESSING	1,779,843	2,638,420		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	82,067	89,976		5.03
5.04	00570	ADMITTING	0	519,108		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	391,504	783,066		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	357,141	1,953,579		5.06
7.00	00700	OPERATION OF PLANT	147,036	1,121,573		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,058		8.00
9.00	00900	HOUSEKEEPING	36,656	346,443		9.00
10.00	01000	DIETARY	5,213	130,838		10.00
11.00	01100	CAFETERIA	-156,315	267,432		11.00
13.00	01300	NURSING ADMINISTRATION	74,552	729,504		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,112	305,587		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-174,687	1,474,422		30.00
31.00	03100	INTENSIVE CARE UNIT	0	750,423		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	5,092	1,078,371		50.00
51.00	05100	RECOVERY ROOM	221	80,701		51.00
51.01	05101	O/P TREATMENT ROOM	0	183,499		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-203,259	1,300,294		54.00
56.00	05600	RADIOISOTOPE	0	112,795		56.00
60.00	06000	LABORATORY	0	967,042		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	60,638		62.00
65.00	06500	RESPIRATORY THERAPY	0	448,329		65.00
66.00	06600	PHYSICAL THERAPY	-496,376	494,681		66.00
67.00	06700	OCCUPATIONAL THERAPY	131,796	138,787		67.00
68.00	06800	SPEECH PATHOLOGY	-4,620	20,440		68.00
69.00	06900	ELECTROCARDIOLOGY	5,017	170,534		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	80,899		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,366	1,151,190		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	588		90.00
91.00	09100	EMERGENCY	0	1,392,047		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,179,219	22,052,112		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PHYSICIAN PRACTICES	0	474,861		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		194.01
194.02	07952	VPCHC	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	4,179,219	22,526,973		200.00

RECLASSIFICATIONS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 10:53 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	241,025	182,722		1.00
	0		241,025	182,722		
500.00	Grand Total: Increases		241,025	182,722		500.00

RECLASSIFICATIONS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 10:53 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	241,025	182,722	0		1.00
	0		241,025	182,722			
500.00	Grand Total: Decreases		241,025	182,722			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2016 10:53 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	339,822	0	0	0	0	1.00
2.00	Land Improvements	269,938	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,407,001	107,479	0	107,479	0	3.00
4.00	Building Improvements	1,645,471	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,720,047	352,481	0	352,481	34,919	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,382,279	459,960	0	459,960	34,919	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,382,279	459,960	0	459,960	34,919	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	339,822	0	1.00
2.00	Land Improvements	269,938	0	2.00
3.00	Buildings and Fixtures	11,514,480	0	3.00
4.00	Building Improvements	1,645,471	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,037,609	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,807,320	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	19,807,320	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2016 10:53 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	775,276	0	798	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	302,763	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,078,039	0	798	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	776,074		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	302,763		2.00
3.00	Total (sum of lines 1-2)	0	1,078,837		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2016 10:53 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	13,769,711	0	13,769,711	0.695183	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,037,609	0	6,037,609	0.304817	0	2.00
3.00	Total (sum of lines 1-2)	19,807,320	0	19,807,320	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,426,012	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	302,763	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,728,775	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	39	0	0	0	1,426,051	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	302,763	2.00
3.00	Total (sum of lines 1-2)	39	0	0	0	1,728,814	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/25/2016 10:53 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-759	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	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	-449,482			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	5,583,988			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/25/2016 10:53 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	CHART FEE REVENUE	B	-3,797	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	DISCOUNT EARNED	B	-11	PURCHASING RECEIVING AND STORES	5.03	0	33.01
33.02	TELEHEALTH	B	-7,610	ADMINISTRATIVE AND GENERAL	5.06	0	33.02
35.00	CAFETERIA REVENUE	B	-172,434	CAFETERIA	11.00	0	35.00
36.00	CAFETERIA REVENUE	B	-5,189	CAFETERIA	11.00	0	36.00
39.00	ADVERTISING	A	-2,571	ADMINISTRATIVE AND GENERAL	5.06	0	39.00
41.00	MISC REVENUE	B	-9,326	ADMINISTRATIVE AND GENERAL	5.06	0	41.00
42.00	VPCHC	B	-6,016	HOUSEKEEPING	9.00	0	42.00
43.00	RENTAL REVENUE	B	-144,502	OPERATION OF PLANT	7.00	0	43.00
44.00	HAF	A	-504,310	ADMINISTRATIVE AND GENERAL	5.06	0	44.00
45.00	PHYSICIAN RECRUITMENT	A	-33,333	ADMINISTRATIVE AND GENERAL	5.06	0	45.00
47.00	EHR DEPRECIATION	A	-65,429	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	47.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		4,179,219				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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2016 10:53 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	716,165	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1,461,480	0	2.00
3.00	5.01	NONPATIENT TELEPHONES	HOME OFFICE	32,403	0	3.00
4.00	5.02	DATA PROCESSING	HOME OFFICE	1,779,843	0	4.00
4.01	5.03	PURCHASING RECEIVING AND STO	HOME OFFICE	82,078	0	4.01
4.02	5.05	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	391,504	0	4.02
4.03	5.06	ADMINISTRATIVE AND GENERAL	HOME OFFICE	914,291	0	4.03
4.04	7.00	OPERATION OF PLANT	HOME OFFICE	291,538	0	4.04
4.05	9.00	HOUSEKEEPING	HOME OFFICE	42,672	0	4.05
4.06	10.00	DIETARY	HOME OFFICE	5,213	0	4.06
4.07	11.00	CAFETERIA	HOME OFFICE	21,308	0	4.07
4.08	13.00	NURSING ADMINISTRATION	HOME OFFICE	74,552	0	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	35,909	0	4.09
4.10	50.00	OPERATING ROOM	HOME OFFICE	5,092	0	4.10
4.11	51.00	RECOVERY ROOM	HOME OFFICE	221	0	4.11
4.12	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	69,944	0	4.12
4.13	66.00	PHYSICAL THERAPY	HOME OFFICE	3,985	0	4.13
4.14	67.00	OCCUPATIONAL THERAPY	HOME OFFICE	1,277	0	4.14
4.15	68.00	SPEECH PATHOLOGY	HOME OFFICE	174	0	4.15
4.16	69.00	ELECTROCARDIOLOGY	HOME OFFICE	6,609	0	4.16
4.17	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	22,366	0	4.17
4.18	66.00	PHYSICAL THERAPY	THERAPY	407,250	907,611	4.18
4.19	67.00	OCCUPATIONAL THERAPY	THERAPY	130,519	0	4.19
4.20	68.00	SPEECH PATHOLOGY	THERAPY	17,736	22,530	4.20
5.00	0		0	6,514,129	930,141	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	G		0.00	TH MEDICAL LAB	100.00	6.00
7.00	G		0.00	UNION HOSPITAL	100.00	7.00
8.00	G		0.00	UNION THERAPY	51.00	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:	OTHER				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: 151326	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/25/2016 10:53 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	716,165	9		1.00
2.00	1,461,480	0		2.00
3.00	32,403	0		3.00
4.00	1,779,843	0		4.00
4.01	82,078	0		4.01
4.02	391,504	0		4.02
4.03	914,291	0		4.03
4.04	291,538	0		4.04
4.05	42,672	0		4.05
4.06	5,213	0		4.06
4.07	21,308	0		4.07
4.08	74,552	0		4.08
4.09	35,909	0		4.09
4.10	5,092	0		4.10
4.11	221	0		4.11
4.12	69,944	0		4.12
4.13	3,985	0		4.13
4.14	1,277	0		4.14
4.15	174	0		4.15
4.16	6,609	0		4.16
4.17	22,366	0		4.17
4.18	-500,361	0		4.18
4.19	130,519	0		4.19
4.20	-4,794	0		4.20
5.00	5,583,988			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	LAB		6.00
7.00	HOME OFFICE		7.00
8.00	THERAPY		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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2016 10:53 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	174,687	174,687	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	273,203	273,203	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	1,592	1,592	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			449,482	449,482	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	174,687		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	273,203		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,592		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	449,482		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,426,051	1,426,051				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	302,763		302,763			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,461,480	0	0	1,461,480		4.00
5.01	00540	NONPATIENT TELEPHONES	68,554	1,511	23,045	0	93,110	5.01
5.02	00550	DATA PROCESSING	2,638,420	2,950	16,049	0	1,070	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	89,976	11,494	311	0	713	5.03
5.04	00570	ADMITTING	519,108	7,323	667	81,535	2,140	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	783,066	4,330	0	3,984	1,427	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,953,579	21,418	11,756	115,520	5,351	5.06
7.00	00700	OPERATION OF PLANT	1,121,573	314,352	10,957	66,381	7,492	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,058	6,016	463	0	0	8.00
9.00	00900	HOUSEKEEPING	346,443	5,696	2,253	39,631	357	9.00
10.00	01000	DIETARY	130,838	14,923	2,566	12,749	713	10.00
11.00	01100	CAFETERIA	267,432	49,941	8,588	43,003	1,784	11.00
13.00	01300	NURSING ADMINISTRATION	729,504	20,081	974	98,894	1,427	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	305,587	12,714	234	32,078	3,211	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,474,422	203,252	16,330	236,039	26,045	30.00
31.00	03100	INTENSIVE CARE UNIT	750,423	5,957	56,583	116,988	2,140	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,078,371	43,374	43,108	51,461	2,497	50.00
51.00	05100	RECOVERY ROOM	80,701	4,374	889	13,348	713	51.00
51.01	05101	O/P TREATMENT ROOM	183,499	23,365	3,259	26,519	3,924	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,300,294	84,931	59,043	148,337	4,994	54.00
56.00	05600	RADIOISOTOPE	112,795	3,822	0	0	357	56.00
60.00	06000	LABORATORY	967,042	24,862	0	0	1,784	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	60,638	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	448,329	8,776	12,776	58,685	2,497	65.00
66.00	06600	PHYSICAL THERAPY	494,681	49,099	2,495	0	3,924	66.00
67.00	06700	OCCUPATIONAL THERAPY	138,787	41,296	261	0	2,854	67.00
68.00	06800	SPEECH PATHOLOGY	20,440	5,580	0	0	713	68.00
69.00	06900	ELECTROCARDIOLOGY	170,534	6,088	3,968	18,240	1,784	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,899	14,763	0	0	357	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,151,190	14,734	1,166	69,659	2,140	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	588	1,162	0	0	0	90.00
91.00	09100	EMERGENCY	1,392,047	122,201	23,395	194,239	10,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,052,112	1,130,385	301,136	1,427,290	93,110	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	474,861	49,752	1,627	34,190	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	131,646	0	0	0	194.01
194.02	07952	VPCHC	0	114,268	0	0	0	194.02
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)	22,526,973	1,426,051	302,763	1,461,480	93,110	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	2,658,489					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	102,494				5.03
5.04	00570	ADMITTING	126,595	210	737,578			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	42,198	0	0	835,005		5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	274,289	7	0	0	2,381,920	5.06
7.00	00700	OPERATION OF PLANT	548,580	32	0	0	2,069,367	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	592	0	0	9,129	8.00
9.00	00900	HOUSEKEEPING	21,099	7,758	0	0	423,237	9.00
10.00	01000	DIETARY	21,099	7	0	0	182,895	10.00
11.00	01100	CAFETERIA	42,198	23	0	0	412,969	11.00
13.00	01300	NURSING ADMINISTRATION	84,396	1	0	0	935,277	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	168,793	3	0	0	522,620	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	232,090	14,568	178,440	53,084	2,434,270	30.00
31.00	03100	INTENSIVE CARE UNIT	21,099	7,760	74,206	14,397	1,049,553	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	84,396	31,556	59,801	57,824	1,452,388	50.00
51.00	05100	RECOVERY ROOM	0	0	1,905	2,493	104,423	51.00
51.01	05101	O/P TREATMENT ROOM	21,099	4,938	869	13,390	280,862	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	189,892	7,497	85,535	240,213	2,120,736	54.00
56.00	05600	RADIOISOTOPE	0	104	2,016	8,865	127,959	56.00
60.00	06000	LABORATORY	21,099	0	79,872	92,585	1,187,244	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	5,020	1,541	67,199	62.00
65.00	06500	RESPIRATORY THERAPY	42,198	2,783	27,726	7,686	611,456	65.00
66.00	06600	PHYSICAL THERAPY	84,396	131	6,613	21,288	662,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,184	6,823	192,205	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	466	927	28,126	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31	31,683	29,919	262,247	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,739	960	100,718	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,297	267	122,293	76,441	1,501,187	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	1,750	90.00
91.00	09100	EMERGENCY	232,090	23,801	55,210	201,169	2,254,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,320,903	102,069	737,578	829,605	21,377,218	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	337,586	425	0	5,400	903,841	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	131,646	194.01
194.02	07952	VPCHC	0	0	0	0	114,268	194.02
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)	2,658,489	102,494	737,578	835,005	22,526,973	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	2,381,920					5.06
7.00	00700	OPERATION OF PLANT	244,678	2,314,045				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,079	16,402	26,610			8.00
9.00	00900	HOUSEKEEPING	50,043	15,530	0	488,810		9.00
10.00	01000	DIETARY	21,625	40,688	0	8,715	253,923	10.00
11.00	01100	CAFETERIA	48,829	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	110,585	54,752	0	11,727	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,794	34,666	0	7,425	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	287,831	554,175	9,268	118,699	183,369	30.00
31.00	03100	INTENSIVE CARE UNIT	124,097	16,243	1,416	3,479	50,848	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	171,727	118,260	1,321	25,330	0	50.00
51.00	05100	RECOVERY ROOM	12,347	11,925	0	2,554	0	51.00
51.01	05101	O/P TREATMENT ROOM	33,209	63,706	0	13,645	19,706	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	250,752	231,567	2,569	49,600	0	54.00
56.00	05600	RADIOISOTOPE	15,130	10,420	0	2,232	0	56.00
60.00	06000	LABORATORY	140,377	67,786	0	14,519	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,945	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	72,297	23,929	132	5,125	0	65.00
66.00	06600	PHYSICAL THERAPY	78,348	133,869	2,631	28,674	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,726	112,594	0	24,117	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,326	15,213	0	3,259	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,008	16,600	390	3,556	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,909	40,252	0	8,622	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	177,497	40,173	0	8,605	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	207	3,169	0	679	0	90.00
91.00	09100	EMERGENCY	266,609	333,187	8,883	71,366	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,245,975	1,955,106	26,610	411,928	253,923	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	106,868	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	15,566	358,939	0	76,882	0	194.01
194.02	07952	VPCHC	13,511	0	0	0	0	194.02
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)	2,381,920	2,314,045	26,610	488,810	253,923	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	461,798					11.00
13.00	01300	NURSING ADMINISTRATION	33,122	1,145,463				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,633	0	649,138			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	112,284	382,606	41,537	4,124,039	0	30.00
31.00	03100	INTENSIVE CARE UNIT	47,280	161,054	11,265	1,465,235	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,702	74,017	45,245	1,909,990	0	50.00
51.00	05100	RECOVERY ROOM	17,207	56,272	1,951	206,679	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	10,478	421,606	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,442	0	187,956	2,901,622	0	54.00
56.00	05600	RADIOISOTOPE	0	0	6,936	162,677	0	56.00
60.00	06000	LABORATORY	0	0	72,445	1,482,371	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1,206	76,350	0	62.00
65.00	06500	RESPIRATORY THERAPY	24,906	84,836	6,014	828,695	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	16,657	922,806	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,339	356,981	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	725	50,649	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,511	5,943	23,411	349,666	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	751	162,252	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	25,475	86,792	59,813	1,899,542	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,805	0	90.00
91.00	09100	EMERGENCY	86,242	293,943	157,409	3,472,493	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	455,804	1,145,463	649,138	20,799,458	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	5,994	0	0	1,016,703	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	583,033	0	194.01
194.02	07952	VPCHC	0	0	0	127,779	0	194.02
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)	461,798	1,145,463	649,138	22,526,973	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,124,039		30.00
31.00	03100	INTENSIVE CARE UNIT	1,465,235		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,909,990		50.00
51.00	05100	RECOVERY ROOM	206,679		51.00
51.01	05101	O/P TREATMENT ROOM	421,606		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,901,622		54.00
56.00	05600	RADIOISOTOPE	162,677		56.00
60.00	06000	LABORATORY	1,482,371		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	76,350		62.00
65.00	06500	RESPIRATORY THERAPY	828,695		65.00
66.00	06600	PHYSICAL THERAPY	922,806		66.00
67.00	06700	OCCUPATIONAL THERAPY	356,981		67.00
68.00	06800	SPEECH PATHOLOGY	50,649		68.00
69.00	06900	ELECTROCARDIOLOGY	349,666		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	162,252		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,899,542		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	5,805		90.00
91.00	09100	EMERGENCY	3,472,493		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,799,458		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	1,016,703		194.00
194.01	07951	MEDICAL OFFICE BUILDING	583,033		194.01
194.02	07952	VPCHC	127,779		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	22,526,973		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	1,511	23,045	24,556	0	5.01
5.02	00550	DATA PROCESSING	0	2,950	16,049	18,999	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	11,494	311	11,805	0	5.03
5.04	00570	ADMITTING	0	7,323	667	7,990	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	4,330	0	4,330	0	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	0	21,418	11,756	33,174	0	5.06
7.00	00700	OPERATION OF PLANT	0	314,352	10,957	325,309	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,016	463	6,479	0	8.00
9.00	00900	HOUSEKEEPING	0	5,696	2,253	7,949	0	9.00
10.00	01000	DIETARY	0	14,923	2,566	17,489	0	10.00
11.00	01100	CAFETERIA	0	49,941	8,588	58,529	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	20,081	974	21,055	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,714	234	12,948	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	203,252	16,330	219,582	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,957	56,583	62,540	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,374	43,108	86,482	0	50.00
51.00	05100	RECOVERY ROOM	0	4,374	889	5,263	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	23,365	3,259	26,624	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,931	59,043	143,974	0	54.00
56.00	05600	RADIOISOTOPE	0	3,822	0	3,822	0	56.00
60.00	06000	LABORATORY	0	24,862	0	24,862	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	8,776	12,776	21,552	0	65.00
66.00	06600	PHYSICAL THERAPY	0	49,099	2,495	51,594	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	41,296	261	41,557	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,580	0	5,580	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,088	3,968	10,056	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,763	0	14,763	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	14,734	1,166	15,900	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,162	0	1,162	0	90.00
91.00	09100	EMERGENCY	0	122,201	23,395	145,596	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,130,385	301,136	1,431,521	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	49,752	1,627	51,379	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	131,646	0	131,646	0	194.01
194.02	07952	VPCHC	0	114,268	0	114,268	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,426,051	302,763	1,728,814	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	24,556					5.01
5.02	00550	DATA PROCESSING	282	19,281				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	188	0	11,993			5.03
5.04	00570	ADMITTING	565	918	25	9,498		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	376	306	0	0	5,012	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,411	1,989	1	0	0	5.06
7.00	00700	OPERATION OF PLANT	1,976	3,981	4	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	69	0	0	8.00
9.00	00900	HOUSEKEEPING	94	153	908	0	0	9.00
10.00	01000	DIETARY	188	153	1	0	0	10.00
11.00	01100	CAFETERIA	470	306	3	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	376	612	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	847	1,224	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,868	1,683	1,705	2,299	320	30.00
31.00	03100	INTENSIVE CARE UNIT	565	153	908	955	87	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	659	612	3,691	770	349	50.00
51.00	05100	RECOVERY ROOM	188	0	0	25	15	51.00
51.01	05101	O/P TREATMENT ROOM	1,035	153	578	11	81	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,317	1,377	877	1,101	1,423	54.00
56.00	05600	RADIOISOTOPE	94	0	12	26	53	56.00
60.00	06000	LABORATORY	470	153	0	1,028	559	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	65	9	62.00
65.00	06500	RESPIRATORY THERAPY	659	306	326	357	46	65.00
66.00	06600	PHYSICAL THERAPY	1,035	612	15	85	128	66.00
67.00	06700	OCCUPATIONAL THERAPY	753	0	0	28	41	67.00
68.00	06800	SPEECH PATHOLOGY	188	0	0	6	6	68.00
69.00	06900	ELECTROCARDIOLOGY	470	0	4	408	181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	94	0	0	48	6	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	565	459	31	1,575	461	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,823	1,683	2,785	711	1,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,556	16,833	11,943	9,498	4,979	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	2,448	50	0	33	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	24,556	19,281	11,993	9,498	5,012	202.00

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		Cost Center Description	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	36,575					5.06
7.00	00700	OPERATION OF PLANT	3,758	335,028				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17	2,375	8,940			8.00
9.00	00900	HOUSEKEEPING	769	2,248	0	12,121		9.00
10.00	01000	DIETARY	332	5,891	0	216	24,270	10.00
11.00	01100	CAFETERIA	750	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,698	7,927	0	291	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	949	5,019	0	184	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,413	80,233	3,114	2,945	17,527	30.00
31.00	03100	INTENSIVE CARE UNIT	1,906	2,352	476	86	4,860	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,638	17,122	444	628	0	50.00
51.00	05100	RECOVERY ROOM	190	1,727	0	63	0	51.00
51.01	05101	O/P TREATMENT ROOM	510	9,223	0	338	1,883	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,851	33,526	863	1,230	0	54.00
56.00	05600	RADIOISOTOPE	232	1,509	0	55	0	56.00
60.00	06000	LABORATORY	2,156	9,814	0	360	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	122	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,110	3,464	44	127	0	65.00
66.00	06600	PHYSICAL THERAPY	1,203	19,382	884	711	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	349	16,301	0	598	0	67.00
68.00	06800	SPEECH PATHOLOGY	51	2,203	0	81	0	68.00
69.00	06900	ELECTROCARDIOLOGY	476	2,403	131	88	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183	5,828	0	214	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	2,726	5,816	0	213	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3	459	0	17	0	90.00
91.00	09100	EMERGENCY	4,095	48,239	2,984	1,770	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,487	283,061	8,940	10,215	24,270	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	1,641	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	239	51,967	0	1,906	0	194.01
194.02	07952	VPCHC	208	0	0	0	0	194.02
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)	36,575	335,028	8,940	12,121	24,270	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	60,058					11.00
13.00	01300	NURSING ADMINISTRATION	4,308	36,267				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,943	0	24,114			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,603	12,114	1,542	368,948	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,149	5,099	418	86,554	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,822	2,343	1,679	120,239	0	50.00
51.00	05100	RECOVERY ROOM	2,238	1,782	72	11,563	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	389	40,825	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,600	0	6,997	204,136	0	54.00
56.00	05600	RADIOISOTOPE	0	0	257	6,060	0	56.00
60.00	06000	LABORATORY	0	0	2,689	42,091	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	45	241	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,239	2,686	223	34,139	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	618	76,267	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	198	59,825	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	27	8,142	0	68.00
69.00	06900	ELECTROCARDIOLOGY	847	188	869	16,121	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	28	21,164	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	3,313	2,748	2,220	36,027	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,641	0	90.00
91.00	09100	EMERGENCY	11,216	9,307	5,843	238,266	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,278	36,267	24,114	1,372,249	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	780	0	0	56,331	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	185,758	0	194.01
194.02	07952	VPCHC	0	0	0	114,476	0	194.02
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)	60,058	36,267	24,114	1,728,814	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	368,948		30.00
31.00	03100	INTENSIVE CARE UNIT	86,554		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	120,239		50.00
51.00	05100	RECOVERY ROOM	11,563		51.00
51.01	05101	O/P TREATMENT ROOM	40,825		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,136		54.00
56.00	05600	RADIOISOTOPE	6,060		56.00
60.00	06000	LABORATORY	42,091		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	241		62.00
65.00	06500	RESPIRATORY THERAPY	34,139		65.00
66.00	06600	PHYSICAL THERAPY	76,267		66.00
67.00	06700	OCCUPATIONAL THERAPY	59,825		67.00
68.00	06800	SPEECH PATHOLOGY	8,142		68.00
69.00	06900	ELECTROCARDIOLOGY	16,121		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,164		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,027		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,641		90.00
91.00	09100	EMERGENCY	238,266		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,372,249		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	56,331		194.00
194.01	07951	MEDICAL OFFICE BUILDING	185,758		194.01
194.02	07952	VPCHC	114,476		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,728,814		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQ FT)	NEW MVBLE EQUIP (EQUIP DEPRN)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (DEVICES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	98,142					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		306,314				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,191,282			4.00
5.01	00540	NONPATIENT TELEPHONES	104	23,315	0	261		5.01
5.02	00550	DATA PROCESSING	203	16,237	0	3	126	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	791	315	0	2	0	5.03
5.04	00570	ADMITTING	504	675	456,985	6	6	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	298	0	22,328	4	2	5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	1,474	11,894	647,462	15	13	5.06
7.00	00700	OPERATION OF PLANT	21,634	11,086	372,051	21	26	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	468	0	0	0	8.00
9.00	00900	HOUSEKEEPING	392	2,279	222,126	1	1	9.00
10.00	01000	DIETARY	1,027	2,596	71,455	2	1	10.00
11.00	01100	CAFETERIA	3,437	8,689	241,025	5	2	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	985	554,278	4	4	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	237	179,792	9	8	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	16,522	1,322,946	73	11	30.00
31.00	03100	INTENSIVE CARE UNIT	410	57,247	655,694	6	1	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,985	43,614	288,426	7	4	50.00
51.00	05100	RECOVERY ROOM	301	899	74,811	2	0	51.00
51.01	05101	O/P TREATMENT ROOM	1,608	3,297	148,633	11	1	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,845	59,735	831,398	14	9	54.00
56.00	05600	RADIOISOTOPE	263	0	0	1	0	56.00
60.00	06000	LABORATORY	1,711	0	0	5	1	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	604	12,926	328,918	7	2	65.00
66.00	06600	PHYSICAL THERAPY	3,379	2,524	0	11	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	264	0	8	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	4,015	102,233	5	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	0	1	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	1,014	1,180	390,424	6	3	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	80	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,410	23,669	1,088,668	30	11	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,794	304,668	7,999,653	261	110	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	3,424	1,646	191,629	0	16	194.00
194.01	07951	MEDICAL OFFICE BUILDING	9,060	0	0	0	0	194.01
194.02	07952	VPCHC	7,864	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,426,051	302,763	1,461,480	93,110	2,658,489	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.530486	0.988407	0.178419	356.743295	21,099.119048	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	24,556	19,281	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	94.084291	153.023810	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (REQUISITIO)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	356,015					5.03
5.04	00570	ADMITTING	729	12,332,985				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	71,961,613			5.05
5.06	00591	ADMINISTRATIVE AND GENERAL	23	0	0	-2,381,920	20,145,053	5.06
7.00	00700	OPERATION OF PLANT	111	0	0	0	2,069,367	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,058	0	0	0	9,129	8.00
9.00	00900	HOUSEKEEPING	26,949	0	0	0	423,237	9.00
10.00	01000	DIETARY	24	0	0	0	182,895	10.00
11.00	01100	CAFETERIA	81	0	0	0	412,969	11.00
13.00	01300	NURSING ADMINISTRATION	2	0	0	0	935,277	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10	0	0	0	522,620	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,603	2,983,617	4,575,025	0	2,434,270	30.00
31.00	03100	INTENSIVE CARE UNIT	26,955	1,240,802	1,240,802	0	1,049,553	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	109,608	999,938	4,983,497	0	1,452,388	50.00
51.00	05100	RECOVERY ROOM	0	31,854	214,897	0	104,423	51.00
51.01	05101	O/P TREATMENT ROOM	17,152	14,535	1,154,051	0	280,862	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,042	1,430,238	20,699,602	0	2,120,736	54.00
56.00	05600	RADIOISOTOPE	362	33,702	763,994	0	127,959	56.00
60.00	06000	LABORATORY	0	1,335,539	7,979,406	0	1,187,244	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	83,940	132,838	0	67,199	62.00
65.00	06500	RESPIRATORY THERAPY	9,668	463,609	662,434	0	611,456	65.00
66.00	06600	PHYSICAL THERAPY	456	110,580	1,834,725	0	662,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	36,524	588,007	0	192,205	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,784	79,902	0	28,126	68.00
69.00	06900	ELECTROCARDIOLOGY	106	529,766	2,578,583	0	262,247	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,527	82,719	0	100,718	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	927	2,044,856	6,588,022	0	1,501,187	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	1,750	90.00
91.00	09100	EMERGENCY	82,673	923,174	17,337,701	0	2,254,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	354,539	12,332,985	71,496,205	-2,381,920	18,995,298	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	1,476	0	465,408	0	903,841	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	131,646	194.01
194.02	07952	VPCHC	0	0	0	0	114,268	194.02
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)	102,494	737,578	835,005		2,381,920	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.287892	0.059805	0.011603		0.118238	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,993	9,498	5,012		36,575	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.033687	0.000770	0.000070		0.001816	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	OPERATION OF PLANT (SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (NUMBER HOUSED)	DIETARY (DIETARY)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	58,409					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	62,704				8.00
9.00	00900	HOUSEKEEPING	392	0	57,603			9.00
10.00	01000	DIETARY	1,027	0	1,027	7,216		10.00
11.00	01100	CAFETERIA	0	0	0	0	8,937	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	0	1,382	0	641	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	0	875	0	438	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	21,839	13,988	5,211	2,173	30.00
31.00	03100	INTENSIVE CARE UNIT	410	3,336	410	1,445	915	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,985	3,113	2,985	0	420	50.00
51.00	05100	RECOVERY ROOM	301	0	301	0	333	51.00
51.01	05101	O/P TREATMENT ROOM	1,608	0	1,608	560	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,845	6,053	5,845	0	1,131	54.00
56.00	05600	RADIOISOTOPE	263	0	263	0	0	56.00
60.00	06000	LABORATORY	1,711	0	1,711	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	604	312	604	0	482	65.00
66.00	06600	PHYSICAL THERAPY	3,379	6,200	3,379	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	2,842	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	384	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	919	419	0	126	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	1,016	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	1,014	0	1,014	0	493	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	80	0	80	0	0	90.00
91.00	09100	EMERGENCY	8,410	20,932	8,410	0	1,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,349	62,704	48,543	7,216	8,821	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	116	194.00
194.01	07951	MEDICAL OFFICE BUILDING	9,060	0	9,060	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,314,045	26,610	488,810	253,923	461,798	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.617953	0.424375	8.485843	35.188886	51.672597	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	335,028	8,940	12,121	24,270	60,058	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.735897	0.142575	0.210423	3.363359	6.720152	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 10:53 am

		Cost Center Description	NURSING ADMINISTRATION (TIME SPENT)	MEDICAL RECORDS & LIBRARY (ASSIGNED TIME)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00591	ADMINISTRATIVE AND GENERAL				5.06
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION	135,304			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	71,496,205		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	45,194	4,575,025		30.00
31.00	03100	INTENSIVE CARE UNIT	19,024	1,240,802		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	8,743	4,983,497		50.00
51.00	05100	RECOVERY ROOM	6,647	214,897		51.00
51.01	05101	O/P TREATMENT ROOM	0	1,154,051		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,699,602		54.00
56.00	05600	RADIOISOTOPE	0	763,994		56.00
60.00	06000	LABORATORY	0	7,979,406		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	132,838		62.00
65.00	06500	RESPIRATORY THERAPY	10,021	662,434		65.00
66.00	06600	PHYSICAL THERAPY	0	1,834,725		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	588,007		67.00
68.00	06800	SPEECH PATHOLOGY	0	79,902		68.00
69.00	06900	ELECTROCARDIOLOGY	702	2,578,583		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	82,719		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,252	6,588,022		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	34,721	17,337,701		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	135,304	71,496,205		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PHYSICIAN PRACTICES	0	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		194.01
194.02	07952	VPCHC	0	0		194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,145,463	649,138		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.465847	0.009079		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,267	24,114		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.268041	0.000337		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,124,039		4,124,039	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,465,235		1,465,235	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,909,990		1,909,990	0	0	50.00
51.00	05100	RECOVERY ROOM	206,679		206,679	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	421,606		421,606	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,901,622		2,901,622	0	0	54.00
56.00	05600	RADIOISOTOPE	162,677		162,677	0	0	56.00
60.00	06000	LABORATORY	1,482,371		1,482,371	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	76,350		76,350	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	828,695	0	828,695	0	0	65.00
66.00	06600	PHYSICAL THERAPY	922,806	0	922,806	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	356,981	0	356,981	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	50,649	0	50,649	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	349,666		349,666	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	162,252		162,252	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	1,899,542		1,899,542	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,805		5,805	0	0	90.00
91.00	09100	EMERGENCY	3,472,493		3,472,493	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,400,358		1,400,358		0	92.00
200.00		Subtotal (see instructions)	22,199,816	0	22,199,816	0	0	200.00
201.00		Less Observation Beds	1,400,358		1,400,358		0	201.00
202.00		Total (see instructions)	20,799,458	0	20,799,458	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,854,043		2,854,043			30.00
31.00	03100	INTENSIVE CARE UNIT	1,240,802		1,240,802			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	999,938	3,983,559	4,983,497	0.383263	0.000000	50.00
51.00	05100	RECOVERY ROOM	31,854	183,043	214,897	0.961758	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	2,237	1,044,958	1,047,195	0.402605	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,403,623	18,571,471	19,975,094	0.145262	0.000000	54.00
56.00	05600	RADIOISOTOPE	33,702	730,292	763,994	0.212930	0.000000	56.00
60.00	06000	LABORATORY	1,335,539	6,643,867	7,979,406	0.185775	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	83,940	48,898	132,838	0.574760	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	463,609	198,825	662,434	1.250985	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	110,580	1,724,145	1,834,725	0.502967	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,524	551,483	588,007	0.607103	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,784	72,118	79,902	0.633889	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	529,766	2,017,046	2,546,812	0.137296	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,527	20,192	82,719	1.961484	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	2,044,856	4,543,166	6,588,022	0.288333	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	923,174	16,414,527	17,337,701	0.200286	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,468	1,576,211	1,654,679	0.846302	0.000000	92.00
200.00		Subtotal (see instructions)	12,242,966	58,323,801	70,566,767			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,242,966	58,323,801	70,566,767			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	O/P TREATMENT ROOM	0.000000		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
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
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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,124,039		4,124,039	0	4,124,039	30.00
31.00	03100	INTENSIVE CARE UNIT	1,465,235		1,465,235	0	1,465,235	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,909,990		1,909,990	0	1,909,990	50.00
51.00	05100	RECOVERY ROOM	206,679		206,679	0	206,679	51.00
51.01	05101	O/P TREATMENT ROOM	421,606		421,606	0	421,606	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,901,622		2,901,622	0	2,901,622	54.00
56.00	05600	RADIOISOTOPE	162,677		162,677	0	162,677	56.00
60.00	06000	LABORATORY	1,482,371		1,482,371	0	1,482,371	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	76,350		76,350	0	76,350	62.00
65.00	06500	RESPIRATORY THERAPY	828,695	0	828,695	0	828,695	65.00
66.00	06600	PHYSICAL THERAPY	922,806	0	922,806	0	922,806	66.00
67.00	06700	OCCUPATIONAL THERAPY	356,981	0	356,981	0	356,981	67.00
68.00	06800	SPEECH PATHOLOGY	50,649	0	50,649	0	50,649	68.00
69.00	06900	ELECTROCARDIOLOGY	349,666		349,666	0	349,666	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	162,252		162,252	0	162,252	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,899,542		1,899,542	0	1,899,542	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,805		5,805	0	5,805	90.00
91.00	09100	EMERGENCY	3,472,493		3,472,493	0	3,472,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,400,358		1,400,358		1,400,358	92.00
200.00		Subtotal (see instructions)	22,199,816	0	22,199,816	0	22,199,816	200.00
201.00		Less Observation Beds	1,400,358		1,400,358		1,400,358	201.00
202.00		Total (see instructions)	20,799,458	0	20,799,458	0	20,799,458	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,854,043		2,854,043			30.00
31.00	03100	INTENSIVE CARE UNIT	1,240,802		1,240,802			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	999,938	3,983,559	4,983,497	0.383263	0.000000	50.00
51.00	05100	RECOVERY ROOM	31,854	183,043	214,897	0.961758	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	2,237	1,044,958	1,047,195	0.402605	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,403,623	18,571,471	19,975,094	0.145262	0.000000	54.00
56.00	05600	RADIOISOTOPE	33,702	730,292	763,994	0.212930	0.000000	56.00
60.00	06000	LABORATORY	1,335,539	6,643,867	7,979,406	0.185775	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	83,940	48,898	132,838	0.574760	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	463,609	198,825	662,434	1.250985	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	110,580	1,724,145	1,834,725	0.502967	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,524	551,483	588,007	0.607103	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	7,784	72,118	79,902	0.633889	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	529,766	2,017,046	2,546,812	0.137296	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,527	20,192	82,719	1.961484	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	2,044,856	4,543,166	6,588,022	0.288333	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	923,174	16,414,527	17,337,701	0.200286	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	78,468	1,576,211	1,654,679	0.846302	0.000000	92.00
200.00		Subtotal (see instructions)	12,242,966	58,323,801	70,566,767			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,242,966	58,323,801	70,566,767			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	O/P TREATMENT ROOM	0.000000		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
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
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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	120,239	4,983,497	0.024127	350,578	8,458	50.00
51.00	05100	RECOVERY ROOM	11,563	214,897	0.053807	12,291	661	51.00
51.01	05101	O/P TREATMENT ROOM	40,825	1,047,195	0.038985	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	204,136	19,975,094	0.010220	397,228	4,060	54.00
56.00	05600	RADIOISOTOPE	6,060	763,994	0.007932	14,767	117	56.00
60.00	06000	LABORATORY	42,091	7,979,406	0.005275	514,396	2,713	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	241	132,838	0.001814	43,040	78	62.00
65.00	06500	RESPIRATORY THERAPY	34,139	662,434	0.051536	254,621	13,122	65.00
66.00	06600	PHYSICAL THERAPY	76,267	1,834,725	0.041569	61,154	2,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,825	588,007	0.101742	20,090	2,044	67.00
68.00	06800	SPEECH PATHOLOGY	8,142	79,902	0.101900	5,886	600	68.00
69.00	06900	ELECTROCARDIOLOGY	16,121	2,546,812	0.006330	316,027	2,000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,164	82,719	0.255854	12,817	3,279	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	36,027	6,588,022	0.005469	1,009,493	5,521	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,641	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	238,266	17,337,701	0.013743	6,138	84	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	130,701	1,654,679	0.078989	0	0	92.00
200.00		Total (lines 50-199)	1,047,448	66,471,922		3,018,526	45,279	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
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
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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,983,497	0.000000	0.000000	350,578	50.00
51.00	05100	RECOVERY ROOM	0	214,897	0.000000	0.000000	12,291	51.00
51.01	05101	O/P TREATMENT ROOM	0	1,047,195	0.000000	0.000000	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,975,094	0.000000	0.000000	397,228	54.00
56.00	05600	RADIOISOTOPE	0	763,994	0.000000	0.000000	14,767	56.00
60.00	06000	LABORATORY	0	7,979,406	0.000000	0.000000	514,396	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	132,838	0.000000	0.000000	43,040	62.00
65.00	06500	RESPIRATORY THERAPY	0	662,434	0.000000	0.000000	254,621	65.00
66.00	06600	PHYSICAL THERAPY	0	1,834,725	0.000000	0.000000	61,154	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	588,007	0.000000	0.000000	20,090	67.00
68.00	06800	SPEECH PATHOLOGY	0	79,902	0.000000	0.000000	5,886	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,546,812	0.000000	0.000000	316,027	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	82,719	0.000000	0.000000	12,817	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	6,588,022	0.000000	0.000000	1,009,493	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	17,337,701	0.000000	0.000000	6,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,654,679	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	66,471,922			3,018,526	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
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
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.383263	0	1,458,108	0	0	50.00
51.00	05100	RECOVERY ROOM	0.961758	0	73,714	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.402605	0	417,936	1,541	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145262	0	5,863,184	305	0	54.00
56.00	05600	RADIOISOTOPE	0.212930	0	315,595	13	0	56.00
60.00	06000	LABORATORY	0.185775	0	2,418,064	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.574760	0	29,786	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.250985	0	82,936	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.502967	0	610,396	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.607103	0	163,713	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.633889	0	4,048	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137296	0	895,746	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.961484	0	3,083	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	0.288333	0	1,907,764	1,060	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.200286	0	4,379,719	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.846302	0	678,239	0	0	92.00
200.00		Subtotal (see instructions)		0	19,302,031	2,919	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	19,302,031	2,919	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	558,839	0		50.00
51.00	05100	RECOVERY ROOM	70,895	0		51.00
51.01	05101	O/P TREATMENT ROOM	168,263	620		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	851,698	44		54.00
56.00	05600	RADIOISOTOPE	67,200	3		56.00
60.00	06000	LABORATORY	449,216	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	17,120	0		62.00
65.00	06500	RESPIRATORY THERAPY	103,752	0		65.00
66.00	06600	PHYSICAL THERAPY	307,009	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	99,391	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,566	0		68.00
69.00	06900	ELECTROCARDIOLOGY	122,982	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,047	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	550,071	306		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	877,196	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	573,995	0		92.00
200.00		Subtotal (see instructions)	4,826,240	973		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,826,240	973		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.383263	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.961758	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.402605	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145262	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.212930	0	0	0	0	56.00
60.00	06000	LABORATORY	0.185775	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.574760	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.250985	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.502967	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.607103	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.633889	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137296	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.961484	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	0.288333	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.200286	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.846302	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	O/P TREATMENT ROOM	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
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
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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,815	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,693	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)	1,739	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	116	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	6	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)	1,095	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)	116	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,124,039	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)	775	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)	171,049	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,952,990	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)	3,952,990	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)	1,467.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,607,329	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)	1,607,329	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,465,235	516	2,839.60	242	687,183	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)	1,053,372	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,347,884	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)	170,274	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)	170,274	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)	954	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,467.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,400,358	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	368,948	3,952,990	0.093334	1,400,358	130,701	90.00
91.00	Nursing School cost	0	3,952,990	0.000000	1,400,358	0	91.00
92.00	Allied health cost	0	3,952,990	0.000000	1,400,358	0	92.00
93.00	All other Medical Education	0	3,952,990	0.000000	1,400,358	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,815	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,693	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)	1,739	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	116	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	6	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)	197	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,124,039	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	170,305	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,953,734	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)	3,953,734	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)	1,468.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	289,226	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	289,226	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,465,235	516	2,839.60	116	329,394	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)	277,247	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	895,867	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)	954	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,468.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,400,615	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	368,948	3,953,734	0.093316	1,400,615	130,700	90.00
91.00	Nursing School cost	0	3,953,734	0.000000	1,400,615	0	91.00
92.00	Allied health cost	0	3,953,734	0.000000	1,400,615	0	92.00
93.00	All other Medical Education	0	3,953,734	0.000000	1,400,615	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,736,620		30.00
31.00	03100	INTENSIVE CARE UNIT		582,000		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.383263	350,578	134,364	50.00
51.00	05100	RECOVERY ROOM	0.961758	12,291	11,821	51.00
51.01	05101	O/P TREATMENT ROOM	0.402605	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145262	397,228	57,702	54.00
56.00	05600	RADIOISOTOPE	0.212930	14,767	3,144	56.00
60.00	06000	LABORATORY	0.185775	514,396	95,562	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.574760	43,040	24,738	62.00
65.00	06500	RESPIRATORY THERAPY	1.250985	254,621	318,527	65.00
66.00	06600	PHYSICAL THERAPY	0.502967	61,154	30,758	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.607103	20,090	12,197	67.00
68.00	06800	SPEECH PATHOLOGY	0.633889	5,886	3,731	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137296	316,027	43,389	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.961484	12,817	25,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288333	1,009,493	291,070	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.200286	6,138	1,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.846302	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,018,526	1,053,372	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)		3,018,526		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.383263	802	307	50.00
51.00	05100	RECOVERY ROOM	0.961758	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.402605	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145262	2,649	385	54.00
56.00	05600	RADIOISOTOPE	0.212930	0	0	56.00
60.00	06000	LABORATORY	0.185775	11,423	2,122	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.574760	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.250985	23,285	29,129	65.00
66.00	06600	PHYSICAL THERAPY	0.502967	23,404	11,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.607103	9,751	5,920	67.00
68.00	06800	SPEECH PATHOLOGY	0.633889	270	171	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137296	2,443	335	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.961484	390	765	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288333	65,395	18,856	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.200286	58	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.846302	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		139,870	69,773	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)		139,870		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		254,819		30.00
31.00	03100	INTENSIVE CARE UNIT		203,015		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.383263	189,501	72,629	50.00
51.00	05100	RECOVERY ROOM	0.961758	5,460	5,251	51.00
51.01	05101	O/P TREATMENT ROOM	0.402605	1,571	632	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145262	232,341	33,750	54.00
56.00	05600	RADIOISOTOPE	0.212930	8,606	1,832	56.00
60.00	06000	LABORATORY	0.185775	229,828	42,696	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.574760	7,988	4,591	62.00
65.00	06500	RESPIRATORY THERAPY	1.250985	37,924	47,442	65.00
66.00	06600	PHYSICAL THERAPY	0.502967	5,026	2,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.607103	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.633889	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137296	49,599	6,810	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.961484	2,734	5,363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288333	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.200286	268,230	53,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.846302	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,038,808	277,247	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,038,808		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.383263	0	0	50.00
51.00	05100	RECOVERY ROOM	0.961758	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.402605	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145262	0	0	54.00
56.00	05600	RADIOISOTOPE	0.212930	0	0	56.00
60.00	06000	LABORATORY	0.185775	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.574760	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.250985	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.502967	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.607103	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.633889	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.137296	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.961484	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.288333	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.200286	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.846302	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151326	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 10:53 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,827,213	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,827,213	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,875,485	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)	37,161	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,351,641	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)	1,486,683	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)	1,486,683	30.00
31.00	Primary payer payments	1,630	31.00
32.00	Subtotal (line 30 minus line 31)	1,485,053	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)	913,533	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	593,796	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	638,788	36.00
37.00	Subtotal (see instructions)	2,078,849	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)	2,078,849	40.00
40.01	Sequestration adjustment (see instructions)	41,577	40.01
41.00	Interim payments	1,991,761	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	45,511	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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,913,985		1,991,761	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	233,700		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)		233,700		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)		3,147,685		1,991,761	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		45,511	6.01
6.02	SETTLEMENT TO PROGRAM		219,418		0	6.02
7.00	Total Medicare program liability (see instructions)		2,928,267		2,037,272	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: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2016 10:53 am

Component CCN: 15Z326 | 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		196,476		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		196,476		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		40,351		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		236,827		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: 151326	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/25/2016 10:53 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	752	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,337	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	75	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,255	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	70,566,767	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,291,965	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	23,107	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	19,576	8.00
9.00	Sequestration adjustment amount (see instructions)	392	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	19,184	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)	19,184	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-2 | Date/Time Prepared: 5/25/2016 10:53 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	171,977	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)	70,471	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	116	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)	242,448	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	242,448	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)	242,448	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	788	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)	241,660	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	241,660	0	19.00
19.01	Sequestration adjustment (see instructions)	4,833	0	19.01
20.00	Interim payments	196,476	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)	40,351	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-2 | Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151326	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/25/2016 10:53 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,347,884	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)	3,347,884	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,381,363	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)	3,381,363	19.00
20.00	Deductibles (exclude professional component)	454,640	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,926,723	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,926,723	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	94,315	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	61,305	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	49,227	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,988,028	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)	2,988,028	30.00
30.01	Sequestration adjustment (see instructions)	59,761	30.01
31.00	Interim payments	3,147,685	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)	-219,418	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-3 Part VII | Date/Time Prepared: 5/25/2016 10:53 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	895,867		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	895,867	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	895,867	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	457,834		8.00
9.00	Ancillary service charges	1,038,808	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,496,642	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,496,642	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	600,775	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	895,867	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	895,867	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	895,867	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	895,867	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	895,867	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	895,867	0	40.00
41.00	Interim payments	302,514	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	593,353	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/25/2016 10:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,812	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	2,932,015	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	305,344	0	0	0	7.00
8.00	Prepaid expenses	23,291,159	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)	26,530,330	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	609,760	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	13,159,951	0	0	0	15.00
16.00	Accumulated depreciation	-11,212,184	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	6,037,609	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,595,136	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,125,466	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	356,366	0	0	0	37.00
38.00	Salaries, wages, and fees payable	853,868	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	898,212	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,108,446	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	820,575	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	820,575	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,929,021	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	32,196,445				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)	32,196,445	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,125,466	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/25/2016 10:53 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		27,941,771		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,254,674				2.00
3.00	Total (sum of line 1 and line 2)		32,196,445		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		32,196,445		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,196,445		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/25/2016 10:53 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,482,500		4,482,500	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	92,525		92,525	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)	4,575,025		4,575,025	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,240,802		1,240,802	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,240,802		1,240,802	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,815,827		5,815,827	17.00
18.00	Ancillary services	7,185,392	41,157,285	48,342,677	18.00
19.00	Outpatient services	923,174	16,414,527	17,337,701	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRACTICES	0	465,408	465,408	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,924,393	58,037,220	71,961,613	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,347,754		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)		18,347,754		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151326 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-3 | Date/Time Prepared: 5/25/2016 10:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,961,613	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,702,554	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,259,059	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,347,754	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,911,305	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	OTHER REVENUE	391,635	24.00
24.01	NON OPERATING	-2,149	24.01
24.02	BAD DEBT	-3,239,325	24.02
25.00	Total other income (sum of lines 6-24)	-2,849,839	25.00
26.00	Total (line 5 plus line 25)	6,061,466	26.00
27.00	ALLOTED EXPENSES	1,806,792	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,806,792	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,254,674	29.00