

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: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 12:51 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/26/2016 Time: 12:51 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 ORTHOPAEDIC HOSPITAL AT PARKVIEW (150167) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	15,751	30,995	21,738	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	15,751	30,995	21,738	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150167		Period: From 01/01/2015 To 12/31/2015		Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 12:48 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 11119 PARKVIEW PLAZA DRIVE		PO Box:						1.00		
2.00	City: FORT WAYNE		State: IN		Zip Code: 46845-1705		County: ALLEN		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		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		ORTHOPAEDIC HOSPITAL AT PARKVIEW	150167	23060	1	11/08/2007	N	P	P	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2015	12/31/2015		20.00		
21.00	Type of Control (see instructions)					4		21.00			
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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	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	0	0	25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 12:48 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	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	XVII	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.	N				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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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		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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>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.</u>							
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	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

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		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
				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.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.						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					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:	49,320	0				118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 12:48 pm	
		1.00	2.00		
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H032	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: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICE		Contractor's Number: 08101	
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600	142.00		
143.00	City: FORT WAYNE	State: IN	Zip Code: 46895-5600	143.00	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			N	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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
				1.00	
Multi campus					
165.00	Is this hospital part of a Multi campus 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
		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	
				1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.25	169.00
				1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014		09/30/2015	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/26/2016 12:48 pm
			1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Prepared: 5/26/2016 12:48 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider 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	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	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.	Y		Y	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: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-2
Part II
Date/Time Prepared:
5/26/2016 12:48 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
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 relieved 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				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.	ERIC		NICKESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406		ERIC.NICKESON@PARKVIEW.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT	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: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	37	13,505	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		37	13,505	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		37	13,505	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					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)		37				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: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	1,769	184	5,233			1.00
2.00 HMO and other (see instructions)	1,265	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,769	184	5,233			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)	1,769	184	5,233	0.00	183.29	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.)				0.00	0.00	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	183.29	27.00
28.00 Observation Bed Days		32	360			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			176			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: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	738	27	2,431	1.00
2.00 HMO and other (see instructions)				567	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		738	27	2,431	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.)	0.00						23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part II
Date/Time Prepared:
5/26/2016 12:48 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	14,378,539	6,468,081	20,846,620	765,201.00	27.24
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	4,962,048	4,962,048	165,197.00	30.04
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		4,804,254	-3,042	4,801,212	205,058.00	23.41
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		0	4,962,048	4,962,048	165,197.00	30.04
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,537,948	0	4,537,948		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		2,886,768	0	2,886,768		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	2,064,697	-2,064,697	0	0.00	0.00
27.00	Administrative & General	5.00	708,559	5,683,929	6,392,488	202,150.00	31.62
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	121,525	281,589	403,114	17,480.00	23.06
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	18,223	294,197	312,420	9,174.00	34.05
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	0	221,865	221,865	5,853.00	37.91
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00
39.00	Central Services and Supply	14.00	0	28,108	28,108	742.00	37.88
40.00	Pharmacy	15.00	0	19,243	19,243	508.00	37.88

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part II
Date/Time Prepared:
5/26/2016 12:48 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	159,711	159,711	5,814.00	27.47	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part III
Date/Time Prepared:
5/26/2016 12:48 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	14,378,539	1,506,033	15,884,572	600,004.00	26.47	1.00
2.00	Excluded area salaries (see instructions)	4,804,254	-3,042	4,801,212	205,058.00	23.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)	9,574,285	1,509,075	11,083,360	394,946.00	28.06	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	4,962,048	4,962,048	165,197.00	30.04	4.00
5.00	Subtotal wage-related costs (see inst.)	4,537,948	0	4,537,948	0.00	40.94	5.00
6.00	Total (sum of lines 3 thru 5)	14,112,233	6,471,123	20,583,356	560,143.00	36.75	6.00
7.00	Total overhead cost (see instructions)	3,072,715	4,464,234	7,536,949	241,721.00	31.18	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2016 12:48 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		472,605	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		454,499	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		76,018	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		4,322,255	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		37,583	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		93,987	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		41,631	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,814,811	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		67,811	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		43,516	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,424,716	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-3
Part V
Date/Time Prepared:
5/26/2016 12:48 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-10

Date/Time Prepared:
5/26/2016 12:48 pm

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.192900	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			555,536	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			-71,999	5.00
6.00	Medicaid charges			9,693,295	6.00
7.00	Medicaid cost (line 1 times line 6)			1,869,837	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,386,300	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)			1,661,403	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14,247,836	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			2,748,408	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			1,087,005	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,473,305	19.00
				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	35,967	706,478	742,445	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	6,938	136,280	143,218	21.00
22.00	Partial payment by patients approved for charity care	0	227	227	22.00
23.00	Cost of charity care (line 21 minus line 22)	6,938	136,053	142,991	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,843,786	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			33,171	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			2,810,615	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			542,168	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			685,159	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,158,464	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		2,567,557	2,567,557	-1,233,490	1,334,067	1.00
2.00	00200		0	0	1,056,443	1,056,443	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	2,064,697	3,436,773	5,501,470	0	5,501,470	4.00
5.00	00500	708,559	14,392,778	15,101,337	1,637	15,102,974	5.00
7.00	00700	121,525	1,556,946	1,678,471	-357	1,678,114	7.00
8.00	00800	0	0	0	0	0	8.00
9.00	00900	18,223	456,882	475,105	0	475,105	9.00
10.00	01000	0	221,865	221,865	0	221,865	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	0	28,108	28,108	0	28,108	14.00
15.00	01500	0	19,243	19,243	0	19,243	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	159,711	23,146	182,857	0	182,857	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,847,815	273,446	2,121,261	-30,116	2,091,145	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,706,048	22,995,262	26,701,310	-20,089,887	6,611,423	50.00
53.00	05300	0	0	0	753,523	753,523	53.00
54.00	05400	288,971	304,354	593,325	-3,116	590,209	54.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	368,433	368,433	0	368,433	60.00
62.00	06200	0	22,070	22,070	0	22,070	62.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	80,373	80,373	0	80,373	65.00
66.00	06600	598,678	17,619	616,297	0	616,297	66.00
69.00	06900	0	850	850	0	850	69.00
71.00	07100	0	0	0	1,821,697	1,821,697	71.00
72.00	07200	0	0	0	17,546,619	17,546,619	72.00
73.00	07300	60,058	1,475,972	1,536,030	0	1,536,030	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	2,716,690	8,059,648	10,776,338	177,047	10,953,385	115.00
118.00		12,290,975	56,301,325	68,592,300	0	68,592,300	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	2,087,564	352,193	2,439,757	0	2,439,757	194.00
200.00		14,378,539	56,653,518	71,032,057	0	71,032,057	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,334,067	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,056,443	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-193,978	5,307,492	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,789,282	17,892,256	5.00
7.00	00700	OPERATION OF PLANT	0	1,678,114	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	475,105	9.00
10.00	01000	DIETARY	0	221,865	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,108	14.00
15.00	01500	PHARMACY	0	19,243	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	182,857	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,091,145	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,611,423	50.00
53.00	05300	ANESTHESIOLOGY	0	753,523	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	590,209	54.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	368,433	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	22,070	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	80,373	65.00
66.00	06600	PHYSICAL THERAPY	0	616,297	66.00
69.00	06900	ELECTROCARDIOLOGY	0	850	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,821,697	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,546,619	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,536,030	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	10,953,385	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,595,304	71,187,604	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	2,439,757	194.00
200.00		TOTAL (SUM OF LINES 118-199)	2,595,304	73,627,361	200.00

RECLASSIFICATIONS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-6

Date/Time Prepared:
5/26/2016 12:48 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - BUILDING DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,056,443	1.00
2.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00	0	177,047	2.00
	0		0	1,233,490	
B - MED AND IV SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	19,368,316	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	19,368,316	
C - TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,637	1.00
2.00		0.00	0	0	2.00
	0		0	1,637	
D - BENEFITS ALLOCATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,064,697	1.00
	0		0	2,064,697	
F - HOME OFFICE					
1.00	ADMINISTRATIVE & GENERAL	5.00	4,962,048	0	1.00
	0		4,962,048	0	
H - PURCHASED SERVICES					
1.00	ADMINISTRATIVE & GENERAL	5.00	721,881	0	1.00
2.00	OPERATION OF PLANT	7.00	281,589	0	2.00
3.00	HOUSEKEEPING	9.00	294,197	0	3.00
4.00	DIETARY	10.00	221,865	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	28,108	0	5.00
6.00	PHARMACY	15.00	19,243	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	26,850	0	7.00
8.00	OPERATING ROOM	50.00	907,838	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	96,940	0	9.00
10.00	LABORATORY	60.00	368,433	0	10.00
11.00	RESPIRATORY THERAPY	65.00	80,373	0	11.00
12.00	PHYSICAL THERAPY	66.00	75	0	12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	523,271	0	13.00
14.00	CLINIC	90.00	3,109	0	14.00
	0		3,573,772	0	
I - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	17,546,619	1.00
	0		0	17,546,619	
J - ANESTHESIA					
1.00	ANESTHESIOLOGY	53.00	0	753,523	1.00
	0		0	753,523	
K - ASC BENEFITS					
1.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00	0	3,042	1.00
	0		0	3,042	
500.00	Grand Total: Increases		8,535,820	40,971,324	500.00

RECLASSIFICATIONS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-6

Date/Time Prepared:
5/26/2016 12:48 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - BUILDING DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,233,490	9		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,233,490			
B - MED AND IV SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	30,116	0		1.00
2.00	OPERATING ROOM	50.00	0	19,335,084	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,116	0		3.00
	0		0	19,368,316			
C - TELEPHONE EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	357	0		1.00
2.00	OPERATING ROOM	50.00	0	1,280	0		2.00
	0		0	1,637			
D - BENEFITS ALLOCATION							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,064,697	0	0		1.00
	0		2,064,697	0			
F - HOME OFFICE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,962,048	0		1.00
	0		0	4,962,048			
H - PURCHASED SERVICES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	721,881	0		1.00
2.00	OPERATION OF PLANT	7.00	0	281,589	0		2.00
3.00	HOUSEKEEPING	9.00	0	294,197	0		3.00
4.00	DIETARY	10.00	0	221,865	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	28,108	0		5.00
6.00	PHARMACY	15.00	0	19,243	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	26,850	0		7.00
8.00	OPERATING ROOM	50.00	0	907,838	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	96,940	0		9.00
10.00	LABORATORY	60.00	0	368,433	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	80,373	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	75	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	523,271	0		13.00
14.00	CLINIC	90.00	0	3,109	0		14.00
	0		0	3,573,772			
I - IMPLANTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	17,546,619	0		1.00
	0		0	17,546,619			
J - ANESTHESIA							
1.00	OPERATING ROOM	50.00	0	753,523	0		1.00
	0		0	753,523			
K - ASC BENEFITS							
1.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00	3,042	0	0		1.00
	0		3,042	0			
500.00	Grand Total: Decreases		2,067,739	47,439,405			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-7
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,446,043	0	0	0	0	3.00
4.00	Building Improvements	3,337,901	842,625	0	842,625	182,614	4.00
5.00	Fixed Equipment	8,786,262	10,198	0	10,198	10,198	5.00
6.00	Movable Equipment	9,732,843	1,515,941	0	1,515,941	207,122	6.00
7.00	HIT designated Assets	2,740,888	257,483	0	257,483	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,043,937	2,626,247	0	2,626,247	399,934	8.00
9.00	Reconciling Items	-182,450	-871,518	0	-871,518	0	9.00
10.00	Total (line 8 minus line 9)	34,226,387	3,497,765	0	3,497,765	399,934	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	9,446,043	668,826				3.00
4.00	Building Improvements	3,997,912	119,037				4.00
5.00	Fixed Equipment	8,786,262	44,171				5.00
6.00	Movable Equipment	11,041,662	2,796,733				6.00
7.00	HIT designated Assets	2,998,371	0				7.00
8.00	Subtotal (sum of lines 1-7)	36,270,250	3,628,767				8.00
9.00	Reconciling Items	-1,053,968	0				9.00
10.00	Total (line 8 minus line 9)	37,324,218	3,628,767				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-7
Part II
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,567,557	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,567,557	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,567,557				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,567,557				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-7
Part III
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	22,230,218	0	22,230,218	0.682399	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,041,661	695,317	10,346,344	0.317601	0	2.00
3.00	Total (sum of lines 1-2)	33,271,879	695,317	32,576,562	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,334,067	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,056,443	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,390,510	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,334,067	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,056,443	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,390,510	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-8

Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2		0				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	2,889,760					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests			0		0.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts			0		0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		0	28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 OTHER OPERATING REVENUE	B	-87,152		ADMINISTRATIVE & GENERAL	5.00		0	33.00
34.00 OTHER OPERATING REVENUE	B	-13,326		ADMINISTRATIVE & GENERAL	5.00		0	34.00

Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8 Date/Time Prepared: 5/26/2016 12:48 pm
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
35.00 SELF INSURANCE OFFSET	A	-193,978	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,595,304				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: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-8-1

Date/Time Prepared:
5/26/2016 12:48 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST REPORT	11,390,950	8,501,190 1.00
2.00	0.00			0	0 2.00
3.00	0.00			0	0 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,390,950	8,501,190 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.

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

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

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

6.00	B	0.00	PARKVIEW HEALTH SYSTEM, INC	60.00	6.00
7.00	B	0.00	NORTHEAST ORTHOPAEDIC HOSPITAL INVE	40.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet A-8-1

Date/Time Prepared:
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	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	2,889,760	0		1.00
2.00	0	9		2.00
3.00	0	9		3.00
4.00	0	0		4.00
5.00	2,889,760			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	HEALTH SYSTEM		6.00
7.00	ORTHOPAEDIC SERVICES		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,334,067	1,334,067			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,056,443		1,056,443		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,307,492	0	0	5,307,492	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	17,892,256	323,872	71,377	1,627,511	5.00
7.00 00700	OPERATION OF PLANT	1,678,114	0	39,633	102,632	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	475,105	0	640	79,541	9.00
10.00 01000	DIETARY	221,865	0	3,924	56,486	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	28,108	0	0	7,156	14.00
15.00 01500	PHARMACY	19,243	0	0	4,899	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	182,857	0	0	40,662	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,091,145	362,647	115,573	477,284	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,611,423	602,760	494,132	1,174,682	50.00
53.00 05300	ANESTHESIOLOGY	753,523	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	590,209	0	329,633	98,252	54.00
58.00 05800	MRI	0	25,319	0	0	58.00
60.00 06000	LABORATORY	368,433	0	0	93,802	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,070	0	0	0	62.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	80,373	0	0	20,463	65.00
66.00 06600	PHYSICAL THERAPY	616,297	19,469	1,531	152,441	66.00
69.00 06900	ELECTROCARDIOLOGY	850	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,821,697	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	17,546,619	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,536,030	0	0	148,514	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	792	90.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	10,953,385	0	0	690,887	115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	71,187,604	1,334,067	1,056,443	4,776,004	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	2,439,757	0	0	531,488	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	73,627,361	1,334,067	1,056,443	5,307,492	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	19,915,016				5.00	
7.00	00700	OPERATION OF PLANT	674,946	2,495,325			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00	
9.00	00900	HOUSEKEEPING	205,885	0	0	761,171	9.00	
10.00	01000	DIETARY	104,660	0	0	0	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	13,075	0	0	0	14.00	
15.00	01500	PHARMACY	8,951	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	82,875	0	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,129,612	895,790	0	273,251	386,935	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,293,567	1,488,901	0	454,172	0	50.00
53.00	05300	ANESTHESIOLOGY	279,385	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	377,481	0	0	0	0	54.00
58.00	05800	MRI	9,388	62,543	0	19,078	0	58.00
60.00	06000	LABORATORY	171,384	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,183	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	37,387	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	292,813	48,091	0	14,670	0	66.00
69.00	06900	ELECTROCARDIOLOGY	315	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	675,434	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,505,775	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	624,582	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	294	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	4,317,370	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,813,362	2,495,325	0	761,171	386,935	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,101,654	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,915,016	2,495,325	0	761,171	386,935	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	0			13.00
14.00	01400	0	0	0	48,339		14.00
15.00	01500	0	0	0	0	33,093	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	0	0	0	60.00
62.00	06200	0	0	0	0	0	62.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	48,339	0	72.00
73.00	07300	0	0	0	0	33,093	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	0	0	0	0	0	115.00
118.00		0	0	0	48,339	33,093	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		0	0	0	48,339	33,093	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150167

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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
		16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0				16.00
17.00	01700	SOCIAL SERVICE	0	306,394			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	306,394	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	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	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	306,394	0	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	306,394	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150167

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From 01/01/2015
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Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM COSTS APPRV					
	22.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				22.00
23.00 02300	PARAMED PRGM-(SPECIFY)		0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	6,038,631	0	6,038,631 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	14,119,637	0	14,119,637 50.00
53.00 05300	ANESTHESIOLOGY	0	0	1,032,908	0	1,032,908 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	1,395,575	0	1,395,575 54.00
58.00 05800	MRI	0	0	116,328	0	116,328 58.00
60.00 06000	LABORATORY	0	0	633,619	0	633,619 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	30,253	0	30,253 62.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	0	0	138,223	0	138,223 65.00
66.00 06600	PHYSICAL THERAPY	0	0	1,145,312	0	1,145,312 66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	1,165	0	1,165 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,497,131	0	2,497,131 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,100,733	0	24,100,733 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	2,342,219	0	2,342,219 73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	1,086	0	1,086 90.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	15,961,642	0	15,961,642 115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	69,554,462	0	69,554,462 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	4,072,899	0	4,072,899 194.00
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	0	73,627,361	0	73,627,361 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,328,556	323,872	71,377	1,723,805	5.00
7.00 00700	OPERATION OF PLANT	0	0	39,633	39,633	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	0	640	640	9.00
10.00 01000	DIETARY	0	0	3,924	3,924	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	362,647	115,573	478,220	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	602,760	494,132	1,096,892	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	329,633	329,633	54.00
58.00 05800	MRI	0	25,319	0	25,319	58.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	19,469	1,531	21,000	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	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	0	0	0	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,328,556	1,334,067	1,056,443	3,719,066	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,328,556	1,334,067	1,056,443	3,719,066	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Period:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	1,723,805				5.00	
7.00	00700	OPERATION OF PLANT	58,421	98,054			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00	
9.00	00900	HOUSEKEEPING	17,821	0	0	18,461	9.00	
10.00	01000	DIETARY	9,059	0	0	0	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	1,132	0	0	0	14.00	
15.00	01500	PHARMACY	775	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	7,173	0	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	97,776	35,200	0	6,627	12,983	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	285,082	58,506	0	11,015	0	50.00
53.00	05300	ANESTHESIOLOGY	24,183	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,674	0	0	0	0	54.00
58.00	05800	MRI	813	2,458	0	463	0	58.00
60.00	06000	LABORATORY	14,835	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	708	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,236	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	25,345	1,890	0	356	0	66.00
69.00	06900	ELECTROCARDIOLOGY	27	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	58,464	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	563,138	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	54,062	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	25	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	373,700	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,628,449	98,054	0	18,461	12,983	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	95,356	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,723,805	98,054	0	18,461	12,983	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	0					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	0			13.00
14.00	01400	0	0	0	1,132		14.00
15.00	01500	0	0	0	0	775	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	0	0	0	60.00
62.00	06200	0	0	0	0	0	62.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	1,132	0	72.00
73.00	07300	0	0	0	0	775	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	0	0	0	0	0	115.00
118.00		0	0	0	1,132	775	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		0	0	0	1,132	775	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

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Part II
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
	16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0				16.00
17.00 01700	SOCIAL SERVICE	0	7,173			17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
20.00 02000	NURSING SCHOOL	0	0	0		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	7,173			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0			50.00
53.00 05300	ANESTHESIOLOGY	0	0			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00
58.00 05800	MRI	0	0			58.00
60.00 06000	LABORATORY	0	0			60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			62.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0			62.30
65.00 06500	RESPIRATORY THERAPY	0	0			65.00
66.00 06600	PHYSICAL THERAPY	0	0			66.00
69.00 06900	ELECTROCARDIOLOGY	0	0			69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.97 07697	CARDIAC REHABILITATION	0	0			76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0			76.98
76.99 07699	LITHOTRIpsy	0	0			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0			90.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0			115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	7,173	0	0	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0			194.00
200.00	Cross Foot Adjustments			0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	7,173	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SERVICES-OTHER PRGM COSTS APPRV					
	22.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				22.00
23.00 02300	PARAMED PRGM-(SPECIFY)		0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS		637,979	0	637,979	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM		1,451,495	0	1,451,495	50.00
53.00 05300	ANESTHESIOLOGY		24,183	0	24,183	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC		362,307	0	362,307	54.00
58.00 05800	MRI		29,053	0	29,053	58.00
60.00 06000	LABORATORY		14,835	0	14,835	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL		708	0	708	62.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY		3,236	0	3,236	65.00
66.00 06600	PHYSICAL THERAPY		48,591	0	48,591	66.00
69.00 06900	ELECTROCARDIOLOGY		27	0	27	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT		58,464	0	58,464	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS		564,270	0	564,270	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		54,837	0	54,837	73.00
76.97 07697	CARDIAC REHABILITATION		0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY		0	0	0	76.98
76.99 07699	LITHOTRIpsy		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC		25	0	25	90.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)		373,700	0	373,700	115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	3,623,710	0	3,623,710
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS		95,356	0	95,356	194.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	3,719,066	0	3,719,066

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	82,090				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		925,429			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	20,846,620		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	19,929	62,525	6,392,488	-19,915,016	5.00
7.00 00700	OPERATION OF PLANT	0	34,718	403,114	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	561	312,420	0	9.00
10.00 01000	DIETARY	0	3,437	221,865	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	28,108	0	14.00
15.00 01500	PHARMACY	0	0	19,243	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	159,711	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	22,315	101,240	1,874,665	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	37,090	432,853	4,613,886	0	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	288,754	385,911	0	54.00
58.00 05800	MRI	1,558	0	0	0	58.00
60.00 06000	LABORATORY	0	0	368,433	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	80,373	0	65.00
66.00 06600	PHYSICAL THERAPY	1,198	1,341	598,753	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	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	0	0	583,329	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	3,109	0	90.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	2,713,648	0	115.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	82,090	925,429	18,759,056	-19,915,016	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	2,087,564	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,334,067	1,056,443	5,307,492	19,915,016	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.251273	1.141571	0.254597	0.370772	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	1,723,805	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.032093	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	62,161				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0			8.00
9.00	00900	HOUSEKEEPING	0	0	62,161		9.00
10.00	01000	DIETARY	0	0	0	23,202	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,315	0	22,315	23,202	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,090	0	37,090	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
58.00	05800	MRI	1,558	0	1,558	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	1,198	0	1,198	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,161	0	62,161	23,202	0 118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,495,325	0	761,171	386,935	0 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	40.142935	0.000000	12.245154	16.676795	0.000000 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	98,054	0	18,461	12,983	0 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.577420	0.000000	0.296987	0.559564	0.000000 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200	0					12.00
13.00	01300	0	0				13.00
14.00	01400	0	0	18,431,805			14.00
15.00	01500	0	0	0	10,000		15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	0	0	0	60.00
62.00	06200	0	0	0	0	0	62.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	18,431,805	0	0	72.00
73.00	07300	0	0	0	10,000	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	0	0	0	0	0	115.00
118.00		0	0	18,431,805	10,000	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		0	0	48,339	33,093	0	202.00
203.00		0.000000	0.000000	0.002623	3.309300	0.000000	203.00
204.00		0	0	1,132	775	0	204.00
205.00		0.000000	0.000000	0.000061	0.077500	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1

Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
				SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
				17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
12.00 01200						12.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500						15.00
16.00 01600						16.00
17.00 01700	10,000					17.00
19.00 01900	0	0				19.00
20.00 02000	0		0			20.00
21.00 02100	0			0		21.00
22.00 02200	0				0	22.00
23.00 02300	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	10,000	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0	0	0	0	0	50.00
53.00 05300	0	0	0	0	0	53.00
54.00 05400	0	0	0	0	0	54.00
58.00 05800	0	0	0	0	0	58.00
60.00 06000	0	0	0	0	0	60.00
62.00 06200	0	0	0	0	0	62.00
62.30 06250	0	0	0	0	0	62.30
65.00 06500	0	0	0	0	0	65.00
66.00 06600	0	0	0	0	0	66.00
69.00 06900	0	0	0	0	0	69.00
71.00 07100	0	0	0	0	0	71.00
72.00 07200	0	0	0	0	0	72.00
73.00 07300	0	0	0	0	0	73.00
76.97 07697	0	0	0	0	0	76.97
76.98 07698	0	0	0	0	0	76.98
76.99 07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	0	0	0	0	0	90.00
92.00 09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	0	0	0	0	0	115.00
118.00	10,000	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	0	0	0	0	0	194.00
200.00						200.00
201.00						201.00
202.00	306,394	0	0	0	0	202.00
203.00	30.639400	0.000000	0.000000	0.000000	0.000000	203.00
204.00	7,173	0	0	0	0	204.00
205.00	0.717300	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet B-1
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		PARAMED PRGM (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	6,038,631		6,038,631	0	6,038,631	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14,119,637		14,119,637	0	14,119,637	50.00
53.00	05300 ANESTHESIOLOGY	1,032,908		1,032,908	0	1,032,908	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,395,575		1,395,575	0	1,395,575	54.00
58.00	05800 MRI	116,328		116,328	0	116,328	58.00
60.00	06000 LABORATORY	633,619		633,619	0	633,619	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	30,253		30,253	0	30,253	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	138,223	0	138,223	0	138,223	65.00
66.00	06600 PHYSICAL THERAPY	1,145,312	0	1,145,312	0	1,145,312	66.00
69.00	06900 ELECTROCARDIOLOGY	1,165		1,165	0	1,165	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,497,131		2,497,131	0	2,497,131	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	24,100,733		24,100,733	0	24,100,733	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,342,219		2,342,219	0	2,342,219	73.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,086		1,086	0	1,086	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	388,685		388,685		388,685	92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	15,961,642		15,961,642		15,961,642	115.00
200.00	Subtotal (see instructions)	69,943,147	0	69,943,147	0	69,943,147	200.00
201.00	Less Observation Beds	388,685		388,685		388,685	201.00
202.00	Total (see instructions)	69,554,462	0	69,554,462	0	69,554,462	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,038,456		7,038,456		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	64,859,160	52,284,985	117,144,145	0.120532	50.00
53.00	05300	ANESTHESIOLOGY	5,537,629	4,314,120	9,851,749	0.104845	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,145,103	1,257,929	2,403,032	0.580756	54.00
58.00	05800	MRI	65,441	9,797,244	9,862,685	0.011795	58.00
60.00	06000	LABORATORY	1,358,904	238,730	1,597,634	0.396598	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	107,518	0	107,518	0.281376	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	617,205	218,815	836,020	0.165335	65.00
66.00	06600	PHYSICAL THERAPY	3,391,099	51,589	3,442,688	0.332680	66.00
69.00	06900	ELECTROCARDIOLOGY	31,978	0	31,978	0.036431	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,151,561	12,086,906	20,238,467	0.123385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,562,359	22,472,341	105,034,700	0.229455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,884,642	3,660,733	13,545,375	0.172917	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,973	0	3,973	0.273345	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	396,440	396,440	0.980438	92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	69,037,898	69,037,898		115.00
200.00		Subtotal (see instructions)	184,755,028	175,817,730	360,572,758		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	184,755,028	175,817,730	360,572,758		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

Title XVIII

Hospital

PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.120532	50.00
53.00	05300 ANESTHESIOLOGY	0.104845	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.580756	54.00
58.00	05800 MRI	0.011795	58.00
60.00	06000 LABORATORY	0.396598	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.281376	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500 RESPIRATORY THERAPY	0.165335	65.00
66.00	06600 PHYSICAL THERAPY	0.332680	66.00
69.00	06900 ELECTROCARDIOLOGY	0.036431	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.123385	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.229455	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.172917	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699 LI THOTRI PSY	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.273345	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.980438	92.00
SPECIAL PURPOSE COST CENTERS			
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)		115.00
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: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	6,038,631		6,038,631	0	6,038,631	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14,119,637		14,119,637	0	14,119,637	50.00
53.00	05300 ANESTHESIOLOGY	1,032,908		1,032,908	0	1,032,908	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,395,575		1,395,575	0	1,395,575	54.00
58.00	05800 MRI	116,328		116,328	0	116,328	58.00
60.00	06000 LABORATORY	633,619		633,619	0	633,619	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	30,253		30,253	0	30,253	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	138,223	0	138,223	0	138,223	65.00
66.00	06600 PHYSICAL THERAPY	1,145,312	0	1,145,312	0	1,145,312	66.00
69.00	06900 ELECTROCARDIOLOGY	1,165		1,165	0	1,165	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,497,131		2,497,131	0	2,497,131	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	24,100,733		24,100,733	0	24,100,733	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,342,219		2,342,219	0	2,342,219	73.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,086		1,086	0	1,086	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	388,685		388,685		388,685	92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	15,961,642		15,961,642		15,961,642	115.00
200.00	Subtotal (see instructions)	69,943,147	0	69,943,147	0	69,943,147	200.00
201.00	Less Observation Beds	388,685		388,685		388,685	201.00
202.00	Total (see instructions)	69,554,462	0	69,554,462	0	69,554,462	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,038,456		7,038,456		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	64,859,160	52,284,985	117,144,145	0.120532	50.00
53.00	05300	ANESTHESIOLOGY	5,537,629	4,314,120	9,851,749	0.104845	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,145,103	1,257,929	2,403,032	0.580756	54.00
58.00	05800	MRI	65,441	9,797,244	9,862,685	0.011795	58.00
60.00	06000	LABORATORY	1,358,904	238,730	1,597,634	0.396598	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	107,518	0	107,518	0.281376	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	617,205	218,815	836,020	0.165335	65.00
66.00	06600	PHYSICAL THERAPY	3,391,099	51,589	3,442,688	0.332680	66.00
69.00	06900	ELECTROCARDIOLOGY	31,978	0	31,978	0.036431	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,151,561	12,086,906	20,238,467	0.123385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,562,359	22,472,341	105,034,700	0.229455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,884,642	3,660,733	13,545,375	0.172917	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,973	0	3,973	0.273345	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	396,440	396,440	0.980438	92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	69,037,898	69,037,898		115.00
200.00		Subtotal (see instructions)	184,755,028	175,817,730	360,572,758		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	184,755,028	175,817,730	360,572,758		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet C
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.120532			50.00
53.00	05300 ANESTHESIOLOGY	0.104845			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.580756			54.00
58.00	05800 MRI	0.011795			58.00
60.00	06000 LABORATORY	0.396598			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.281376			62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.165335			65.00
66.00	06600 PHYSICAL THERAPY	0.332680			66.00
69.00	06900 ELECTROCARDIOLOGY	0.036431			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.123385			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.229455			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.172917			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LI THOTRI PSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.273345			90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.980438			92.00
SPECIAL PURPOSE COST CENTERS					
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)				115.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 150167

Period: From 01/01/2015 To 12/31/2015

Worksheet C Part II Date/Time Prepared: 5/26/2016 12:48 pm

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	14,119,637	1,451,495	12,668,142	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1,032,908	24,183	1,008,725	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,395,575	362,307	1,033,268	0	0	54.00
58.00	05800 MRI	116,328	29,053	87,275	0	0	58.00
60.00	06000 LABORATORY	633,619	14,835	618,784	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	30,253	708	29,545	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	138,223	3,236	134,987	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,145,312	48,591	1,096,721	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	1,165	27	1,138	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,497,131	58,464	2,438,667	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	24,100,733	564,270	23,536,463	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,342,219	54,837	2,287,382	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,086	25	1,061	0	0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	388,685	41,065	347,620	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	15,961,642	373,700	15,587,942	0	0	115.00
200.00	Subtotal (sum of lines 50 thru 199)	63,904,516	3,026,796	60,877,720	0	0	200.00
201.00	Less Observation Beds	388,685	41,065	347,620	0	0	201.00
202.00	Total (line 200 minus line 201)	63,515,831	2,985,731	60,530,100	0	0	202.00

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

Provider CCN: 150167

Period: From 01/01/2015 To 12/31/2015

Worksheet C Part II Date/Time Prepared: 5/26/2016 12:48 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	14,119,637	117,144,145	0.120532	50.00
53.00	05300 ANESTHESIOLOGY	1,032,908	9,851,749	0.104845	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,395,575	2,403,032	0.580756	54.00
58.00	05800 MRI	116,328	9,862,685	0.011795	58.00
60.00	06000 LABORATORY	633,619	1,597,634	0.396598	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	30,253	107,518	0.281376	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500 RESPIRATORY THERAPY	138,223	836,020	0.165335	65.00
66.00	06600 PHYSICAL THERAPY	1,145,312	3,442,688	0.332680	66.00
69.00	06900 ELECTROCARDIOLOGY	1,165	31,978	0.036431	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,497,131	20,238,467	0.123385	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	24,100,733	105,034,700	0.229455	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,342,219	13,545,375	0.172917	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699 LI THOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1,086	3,973	0.273345	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	388,685	396,440	0.980438	92.00
SPECIAL PURPOSE COST CENTERS					
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	15,961,642	69,037,898	0.231201	115.00
200.00	Subtotal (sum of lines 50 thru 199)	63,904,516	353,534,302		200.00
201.00	Less Observation Beds	388,685	0		201.00
202.00	Total (line 200 minus line 201)	63,515,831	353,534,302		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150167		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/26/2016 12:48 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	637,979	0	637,979	5,593	114.07	
200.00	Total (Lines 30-199)	637,979		637,979	5,593	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	1,769	201,790				
200.00	Total (Lines 30-199)	1,769	201,790				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/26/2016 12:48 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,451,495	117,144,145	0.012391	19,246,535	238,484	50.00
53.00	05300 ANESTHESIOLOGY	24,183	9,851,749	0.002455	1,754,078	4,306	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	362,307	2,403,032	0.150771	640,379	96,551	54.00
58.00	05800 MRI	29,053	9,862,685	0.002946	26,062	77	58.00
60.00	06000 LABORATORY	14,835	1,597,634	0.009286	475,456	4,415	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	708	107,518	0.006585	77,303	509	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	3,236	836,020	0.003871	180,616	699	65.00
66.00	06600 PHYSICAL THERAPY	48,591	3,442,688	0.014114	1,065,233	15,035	66.00
69.00	06900 ELECTROCARDIOLOGY	27	31,978	0.000844	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58,464	20,238,467	0.002889	2,568,784	7,421	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	564,270	105,034,700	0.005372	24,496,701	131,596	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	54,837	13,545,375	0.004048	3,039,824	12,305	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	25	3,973	0.006292	1,256	8	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	41,065	396,440	0.103584	0	0	92.00
200.00	Total (lines 50-199)	2,653,096	284,496,404		53,572,227	511,406	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150167		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/26/2016 12:48 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,593	0.00	1,769	0		30.00
200.00		Total (lines 30-199)	5,593		1,769	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet D
Part IV
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		Title XVIII				Hospital	PPS
		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	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	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	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet D
Part IV
Date/Time Prepared:
5/26/2016 12:48 pm

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	117,144,145	0.000000	0.000000	19,246,535	50.00
53.00	05300 ANESTHESIOLOGY	0	9,851,749	0.000000	0.000000	1,754,078	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,403,032	0.000000	0.000000	640,379	54.00
58.00	05800 MRI	0	9,862,685	0.000000	0.000000	26,062	58.00
60.00	06000 LABORATORY	0	1,597,634	0.000000	0.000000	475,456	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	107,518	0.000000	0.000000	77,303	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	836,020	0.000000	0.000000	180,616	65.00
66.00	06600 PHYSICAL THERAPY	0	3,442,688	0.000000	0.000000	1,065,233	66.00
69.00	06900 ELECTROCARDIOLOGY	0	31,978	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,238,467	0.000000	0.000000	2,568,784	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	105,034,700	0.000000	0.000000	24,496,701	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13,545,375	0.000000	0.000000	3,039,824	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	3,973	0.000000	0.000000	1,256	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	396,440	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	284,496,404			53,572,227	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet D
Part IV
Date/Time Prepared:
5/26/2016 12:48 pm

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	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	6,643,515	0	50.00
53.00	05300 ANESTHESIOLOGY	0	568,176	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	121,238	0	54.00
58.00	05800 MRI	0	1,595,794	0	58.00
60.00	06000 LABORATORY	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	8,785	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	833,578	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,786,533	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	445,671	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	31,781	0	92.00
200.00	Total (lines 50-199)	0	12,035,071	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet D
Part V
Date/Time Prepared:
5/26/2016 12:48 pm

		Title XVIII		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.120532	6,643,515	0	0	800,756	50.00
53.00	05300	ANESTHESIOLOGY	0.104845	568,176	0	0	59,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.580756	121,238	0	0	70,410	54.00
58.00	05800	MRI	0.011795	1,595,794	0	0	18,822	58.00
60.00	06000	LABORATORY	0.396598	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.281376	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.165335	8,785	0	0	1,452	65.00
66.00	06600	PHYSICAL THERAPY	0.332680	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.036431	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.123385	833,578	0	0	102,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.229455	1,786,533	0	0	409,929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172917	445,671	0	0	77,064	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.273345	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.980438	31,781	0	0	31,159	92.00
200.00		Subtotal (see instructions)		12,035,071	0	0	1,572,013	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		12,035,071	0	0	1,572,013	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/26/2016 12:48 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
58.00 05800 MRI	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150167		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part I Date/Time Prepared: 5/26/2016 12:48 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	637,979	0	637,979	5,593	114.07	
200.00	Total (Lines 30-199)	637,979		637,979	5,593	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	184	20,989				
200.00	Total (Lines 30-199)	184	20,989				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Prepared: 5/26/2016 12:48 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,451,495	117,144,145	0.012391	2,589,716	32,089	50.00
53.00	05300 ANESTHESIOLOGY	24,183	9,851,749	0.002455	252,860	621	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	362,307	2,403,032	0.150771	64,237	9,685	54.00
58.00	05800 MRI	29,053	9,862,685	0.002946	0	0	58.00
60.00	06000 LABORATORY	14,835	1,597,634	0.009286	51,186	475	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	708	107,518	0.006585	3,308	22	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	3,236	836,020	0.003871	20,740	80	65.00
66.00	06600 PHYSICAL THERAPY	48,591	3,442,688	0.014114	115,309	1,627	66.00
69.00	06900 ELECTROCARDIOLOGY	27	31,978	0.000844	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	58,464	20,238,467	0.002889	325,743	941	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	564,270	105,034,700	0.005372	3,384,183	18,180	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	54,837	13,545,375	0.004048	410,476	1,662	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	25	3,973	0.006292	444	3	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	41,065	396,440	0.103584	0	0	92.00
200.00	Total (lines 50-199)	2,653,096	284,496,404		7,218,202	65,385	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150167		Period: From 01/01/2015 To 12/31/2015		Worksheet D Part III Date/Time Prepared: 5/26/2016 12:48 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,593	0.00	184	0		30.00
200.00		Total (lines 30-199)	5,593		184	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet D
Part IV
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		Title XIX			Hospital		PPS
		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	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	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	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet D
Part IV
Date/Time Prepared:
5/26/2016 12:48 pm

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)	Hospital			
					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	117,144,145	0.000000	0.000000	2,589,716	50.00
53.00	05300	ANESTHESIOLOGY	0	9,851,749	0.000000	0.000000	252,860	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,403,032	0.000000	0.000000	64,237	54.00
58.00	05800	MRI	0	9,862,685	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	1,597,634	0.000000	0.000000	51,186	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	107,518	0.000000	0.000000	3,308	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	836,020	0.000000	0.000000	20,740	65.00
66.00	06600	PHYSICAL THERAPY	0	3,442,688	0.000000	0.000000	115,309	66.00
69.00	06900	ELECTROCARDIOLOGY	0	31,978	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,238,467	0.000000	0.000000	325,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	105,034,700	0.000000	0.000000	3,384,183	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,545,375	0.000000	0.000000	410,476	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,973	0.000000	0.000000	444	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	396,440	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	284,496,404			7,218,202	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet D
Part IV
Date/Time Prepared:
5/26/2016 12:48 pm

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
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
58.00	05800 MRI	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
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: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/26/2016 12:48 pm
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.120532	0	7,034,779	0	0
53.00 05300 ANESTHESIOLOGY	0.104845	0	658,017	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.580756	0	28,537	0	0
58.00 05800 MRI	0.011795	0	883,710	0	0
60.00 06000 LABORATORY	0.396598	0	0	0	0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.281376	0	0	0	0
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.165335	0	5,205	0	0
66.00 06600 PHYSICAL THERAPY	0.332680	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.036431	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.123385	0	663,490	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.229455	0	1,319,515	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.172917	0	540,934	0	0
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.273345	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.980438	0	38,142	0	0
200.00 Subtotal (see instructions)		0	11,172,329	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	11,172,329	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Prepared: 5/26/2016 12:48 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	847,916	0		50.00
53.00 05300 ANESTHESIOLOGY	68,990	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	16,573	0		54.00
58.00 05800 MRI	10,423	0		58.00
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	861	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81,865	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	302,769	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	93,537	0		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	37,396	0		92.00
200.00 Subtotal (see instructions)	1,460,330	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	1,460,330	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/26/2016 12:48 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,593	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,593	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)		5,233	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,769	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,038,631	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,038,631	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)		6,038,631	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)		1,079.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,909,954	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)		1,909,954	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/26/2016 12:48 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					9,934,320 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,844,274 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)					201,790 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					511,406 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					713,196 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,131,078 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)					360 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,079.68 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					388,685 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150167		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/26/2016 12:48 pm	
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	637,979	6,038,631	0.105650	388,685	41,065	90.00
91.00	Nursing School cost	0	6,038,631	0.000000	388,685	0	91.00
92.00	Allied health cost	0	6,038,631	0.000000	388,685	0	92.00
93.00	All other Medical Education	0	6,038,631	0.000000	388,685	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/26/2016 12:48 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,593	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,593	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)		5,233	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		184	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,038,631	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,038,631	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)		6,038,631	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)		1,079.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		198,661	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)		198,661	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150167		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 5/26/2016 12:48 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,326,791		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,525,452		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)					20,989		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					65,385		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					86,374		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,439,078		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)					360		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,079.68		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					388,685		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150167		Period: From 01/01/2015 To 12/31/2015		Worksheet D-1 Date/Time Prepared: 5/26/2016 12:48 pm	
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	637,979	6,038,631	0.105650	388,685	41,065	90.00
91.00	Nursing School cost	0	6,038,631	0.000000	388,685	0	91.00
92.00	Allied health cost	0	6,038,631	0.000000	388,685	0	92.00
93.00	All other Medical Education	0	6,038,631	0.000000	388,685	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/26/2016 12:48 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,360,615		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.120532	19,246,535	2,319,823	50.00
53.00	05300 ANESTHESIOLOGY	0.104845	1,754,078	183,906	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.580756	640,379	371,904	54.00
58.00	05800 MRI	0.011795	26,062	307	58.00
60.00	06000 LABORATORY	0.396598	475,456	188,565	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.281376	77,303	21,751	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.165335	180,616	29,862	65.00
66.00	06600 PHYSICAL THERAPY	0.332680	1,065,233	354,382	66.00
69.00	06900 ELECTROCARDIOLOGY	0.036431	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.123385	2,568,784	316,949	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.229455	24,496,701	5,620,891	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.172917	3,039,824	525,637	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.273345	1,256	343	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.980438	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		53,572,227	9,934,320	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		53,572,227		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Prepared: 5/26/2016 12:48 pm	
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		243,588		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.120532	2,589,716	312,144	50.00
53.00	05300 ANESTHESIOLOGY	0.104845	252,860	26,511	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.580756	64,237	37,306	54.00
58.00	05800 MRI	0.011795	0	0	58.00
60.00	06000 LABORATORY	0.396598	51,186	20,300	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.281376	3,308	931	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.165335	20,740	3,429	65.00
66.00	06600 PHYSICAL THERAPY	0.332680	115,309	38,361	66.00
69.00	06900 ELECTROCARDIOLOGY	0.036431	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.123385	325,743	40,192	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.229455	3,384,183	776,518	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.172917	410,476	70,978	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.273345	444	121	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.980438	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		7,218,202	1,326,791	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		7,218,202		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/26/2016 12:48 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		6,867,293	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,536,164	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		32,871	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		7,147,352	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		36.01	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (F)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/26/2016 12:48 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000004111	0.000004054	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		9,436,328		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		9,436,328		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		750,297		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,186,625		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,186,625		61.00
62.00	Deductibles billed to program beneficiaries		913,018		62.00
63.00	Coinurance billed to program beneficiaries		0		63.00
64.00	Allowable bad debts (see instructions)		7,988		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		5,192		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,274		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,278,799		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		80,401		70.93
70.94	HRR adjustment amount (see instructions)		0		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Date/Time Prepared: 5/26/2016 12:48 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,359,200		71.00
71.01	Sequestration adjustment (see instructions)		187,184		71.01
72.00	Interim payments		9,156,265		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		15,751		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		0		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 12:48 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,572,013	2.00
3.00	PPS payments		1,883,999	3.00
4.00	Outlier payment (see instructions)		23,950	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)		0	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 charge basis 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)		0	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)		1,907,949	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		399,745	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	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)		1,508,204	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)		1,508,204	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,508,204	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)		43,044	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		27,979	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,561	36.00
37.00	Subtotal (see instructions)		1,536,183	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)		1,536,183	40.00
40.01	Sequestration adjustment (see instructions)		30,724	40.01
41.00	Interim payments		1,474,464	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		30,995	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: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2016 12:48 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		9,156,265		1,474,464	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)		9,156,265		1,474,464	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		15,751		30,995	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		9,172,016		1,505,459	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: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet E-1
Part II
Date/Time Prepared:
5/26/2016 12:48 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			2,431 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			1,769 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,265 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			5,233 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			360,572,758 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			742,445 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			327,742 8.00
9.00	Sequestration adjustment amount (see instructions)			6,555 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			321,187 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			299,449 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)			21,738 32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet G
Date/Time Prepared:
5/26/2016 12:48 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	9,688,482	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	18,204,287	0	0	0	4.00
5.00	Other receivable	-56,379	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	-1,490,810	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)	26,345,580	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,446,043	0	0	0	15.00
16.00	Accumulated depreciation	-2,000,018	0	0	0	16.00
17.00	Leasehold improvements	3,997,913	0	0	0	17.00
18.00	Accumulated depreciation	-1,117,245	0	0	0	18.00
19.00	Fixed equipment	157,301	0	0	0	19.00
20.00	Accumulated depreciation	-74,560	0	0	0	20.00
21.00	Automobiles and trucks	21,045	0	0	0	21.00
22.00	Accumulated depreciation	-2,192	0	0	0	22.00
23.00	Major movable equipment	19,649,577	0	0	0	23.00
24.00	Accumulated depreciation	-9,938,574	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)	20,139,290	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	57,506,375	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	57,506,375	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	103,991,245	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,501,706	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,580,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	768,429	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,850,135	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,324,150	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	12,962,168	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	21,286,318	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,136,453	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	67,854,792				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)	67,854,792	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	103,991,245	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet G-1

Date/Time Prepared:
5/26/2016 12:48 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		128,053,274		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		73,001,518			2.00
3.00	Total (sum of line 1 and line 2)		201,054,792		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		201,054,792		0	11.00
12.00	TRANSFERS	133,200,000		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		133,200,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		67,854,792		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	TRANSFERS		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: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2016 12:48 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	7,151,700		7,151,700	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,151,700		7,151,700	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,151,700		7,151,700	17.00
18.00	Ancillary services	182,339,158		182,339,158	18.00
19.00	Outpatient services	0	101,512,015	101,512,015	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.)	0	81,669,212	81,669,212	25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	189,490,858	183,181,227	372,672,085	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		71,032,057		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)		71,032,057		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150167

Period:
From 01/01/2015
To 12/31/2015

Worksheet G-3

Date/Time Prepared:
5/26/2016 12:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	372,672,085	1.00
2.00	Less contractual allowances and discounts on patients' accounts	229,252,973	2.00
3.00	Net patient revenues (line 1 minus line 2)	143,419,112	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	71,032,057	4.00
5.00	Net income from service to patients (line 3 minus line 4)	72,387,055	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-6,895	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	687,081	24.00
25.00	Total other income (sum of lines 6-24)	680,186	25.00
26.00	Total (line 5 plus line 25)	73,067,241	26.00
27.00	GAIN ON SALE OF ASSET	65,723	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	65,723	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	73,001,518	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150167	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/26/2016 12:48 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		748,063	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,234	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		14.82	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		750,297	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00