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: 150104	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/24/2016 3:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2016 Time: 3:25 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WITHAM MEMORIAL HOSPITAL (150104) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	59,991	70,064	-11,940	-231,025	1.00
2.00	Subprovider - IPF	0	3	-118		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	59,994	69,946	-11,940	-231,025	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2016 2:21 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2605 N. LEBANON STREET	PO Box:			1.00
2.00	City: LEBANON	State: IN	Zip Code: 46052-	County: BOONE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	WITHAM MEMORIAL HOSPITAL	150104	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	WITHAM HOSPITAL GEROPSYCH	15S104	26900	4	01/01/2000	N	P	N	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	WITHAM HOSPITAL ECU	155832	26900		05/07/2015	N	P	N	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)	9		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.	Y	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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	245	1,068	0	0	747	65	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 2:21 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	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 2:21 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 2:21 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2016 2:21 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	189,626	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 2:21 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)	N		140.00

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

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150104	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 2:21 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: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2016 2:21 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/08/2016	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2016 2:21 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2016 2:21 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/08/2016			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2016 2:21 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	60	21,900	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)		60	21,900	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		68	24,820	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	18	4,284		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		96				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: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2016 2:21 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,174	245	4,758			1.00
2.00	HMO and other (see instructions)	604	1,815				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)	2,174	245	4,758			7.00
8.00	INTENSIVE CARE UNIT	664	0	1,563			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	1,030			13.00
14.00	Total (see instructions)	2,838	245	7,351	0.00	609.61	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,358	0	2,827	0.00	20.98	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	1,350	0	1,738	0.00	9.68	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	640.27	27.00
28.00	Observation Bed Days		268	1,109			28.00
29.00	Ambulance Trips	1,707					29.00
30.00	Employee discount days (see instruction)			168			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	65	86			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: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2016 2:21 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	911	68	2,266	1.00
2.00	HMO and other (see instructions)			181	460		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	911	68	2,266	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	202	0	250	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2016 2:21 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	42,083,082	2,792,289	44,875,371	1,331,754.00	33.70	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	572,206	2,616	574,822	20,135.00	28.55	9.00
10.00	Excluded area salaries (see instructions)		17,792,307	2,031,438	19,823,745	474,194.00	41.81	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		662,686	0	662,686	9,597.00	69.05	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,378,857	0	9,378,857			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		5,910,557	0	5,910,557			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	599,663	6,276	605,939	10,680.00	56.74	26.00
27.00	Administrative & General	5.00	5,346,079	340,456	5,686,535	181,964.00	31.25	27.00
28.00	Administrative & General under contract (see inst.)		662,903	0	662,903	8,619.00	76.91	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	412,861	13,590	426,451	20,555.00	20.75	30.00
31.00	Laundry & Linen Service	8.00	22,398	545	22,943	3,598.00	6.38	31.00
32.00	Housekeeping	9.00	350,186	8,434	358,620	27,272.00	13.15	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	671,051	-304,596	366,455	15,233.00	24.06	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	319,351	319,351	25,864.00	12.35	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	468,698	11,061	479,759	10,636.00	45.11	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	413,980	9,964	423,944	20,281.00	20.90	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2016 2:21 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	931,978	18,337	950,315	35,167.00	27.02	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2016 2:21 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)		42,745,985	2,792,289	45,538,274	1,340,373.00	33.97	1.00
2.00	Excluded area salaries (see instructions)		18,364,513	2,034,054	20,398,567	494,329.00	41.27	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,381,472	758,235	25,139,707	846,044.00	29.71	3.00
4.00	Subtotal other wages & related costs (see inst.)		662,686	0	662,686	9,597.00	69.05	4.00
5.00	Subtotal wage-related costs (see inst.)		9,378,857	0	9,378,857	0.00	37.31	5.00
6.00	Total (sum of lines 3 thru 5)		34,423,015	758,235	35,181,250	855,641.00	41.12	6.00
7.00	Total overhead cost (see instructions)		9,879,797	423,418	10,303,215	359,869.00	28.63	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2016 2:21 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,911,727	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	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	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	10,273,912	8.00
9.00	Prescription Drug Plan	65,313	9.00
10.00	Dental, Hearing and Vision Plan	-100,303	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	63,144	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)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	145,776	14.00
15.00	'Workers' Compensation Insurance	275,555	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	2,644,016	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	10,274	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,289,414	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: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V | Date/Time Prepared: 5/24/2016 2:21 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	0	0	3.00
4.00	Subprovider - IRF	0	0	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-7 | Date/Time Prepared: 5/24/2016 2:21 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	14	0	14	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	25	0	25	12.00
13.00		RUB	72	0	72	13.00
14.00		RUA	77	0	77	14.00
15.00		RVC	282	0	282	15.00
16.00		RVB	180	0	180	16.00
17.00		RVA	396	0	396	17.00
18.00		RHC	86	0	86	18.00
19.00		RHB	42	0	42	19.00
20.00		RHA	70	0	70	20.00
21.00		RMC	8	0	8	21.00
22.00		RMB	1	0	1	22.00
23.00		RMA	43	0	43	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	4	0	4	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	13	0	13	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	5	0	5	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	6	0	6	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	26	0	26	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-7 | Date/Time Prepared: 5/24/2016 2:21 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,350	0	1,350	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	29500	29500	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	572,206	67.56	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	4,069	0.48	N	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	847,004			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/24/2016 2:21 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)	0.205091	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,608,969	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	20,403,791	6.00
7.00	Medicaid cost (line 1 times line 6)	4,184,634	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,884,874	0	2,884,874	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	591,662	0	591,662	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	591,662	0	591,662	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	13,234,022	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	134,673	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	13,099,349	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,686,559	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,278,221	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,278,221	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,105,431	2,105,431	179,339	2,284,770	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	2,714,603	2,714,603	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	599,663	12,741,380	13,341,043	-2,595,993	10,745,050	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,346,079	15,693,509	21,039,588	-1,076,874	19,962,714	5.00
7.00	00700	OPERATION OF PLANT	412,861	2,570,295	2,983,156	-61,002	2,922,154	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,398	238,874	261,272	477	261,749	8.00
9.00	00900	HOUSEKEEPING	350,186	173,048	523,234	6,910	530,144	9.00
10.00	01000	DIETARY	671,051	708,487	1,379,538	-722,579	656,959	10.00
11.00	01100	CAFETERIA	0	0	0	732,827	732,827	11.00
13.00	01300	NURSING ADMINISTRATION	468,698	72,194	540,892	-18,729	522,163	13.00
15.00	01500	PHARMACY	413,980	1,830,994	2,244,974	-1,053,215	1,191,759	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	931,978	286,153	1,218,131	13,535	1,231,666	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,666,842	908,270	3,575,112	-118,156	3,456,956	30.00
31.00	03100	INTENSIVE CARE UNIT	938,040	349,274	1,287,314	-52,869	1,234,445	31.00
40.00	04000	SUBPROVIDER - IPF	1,131,384	252,534	1,383,918	15,179	1,399,097	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	4,040	4,040	0	4,040	43.00
44.00	04400	SKILLED NURSING FACILITY	572,206	249,978	822,184	-53,168	769,016	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,892,537	6,073,687	7,966,224	-4,396,657	3,569,567	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,063,460	2,358,515	3,421,975	-86,096	3,335,879	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	284,219	107,646	391,865	1,632	393,497	55.01
57.00	05700	CT SCAN	105,568	519,735	625,303	-261	625,042	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	304,789	801,286	1,106,075	-274,023	832,052	58.00
59.00	05900	CARDIAC CATHETERIZATION	166,168	519,118	685,286	-219,432	465,854	59.00
60.00	06000	LABORATORY	1,915,948	3,302,567	5,218,515	-148,825	5,069,690	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	36,452	36,452	-27	36,425	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,075,393	254,788	1,330,181	7,457	1,337,638	66.00
67.00	06700	OCCUPATIONAL THERAPY	322,040	34,158	356,198	-11,359	344,839	67.00
67.01	06701	AUDIOLOGY	157,899	198,557	356,456	3,683	360,139	67.01
68.00	06800	SPEECH PATHOLOGY	79,185	8,365	87,550	1,453	89,003	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	751,463	178,047	929,510	-27,705	901,805	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,007	1,007	2,148,446	2,149,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,664,266	2,664,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,023,179	1,023,179	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	181,193	127,066	308,259	-3,088	305,171	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	1,684	1,684	0	1,684	90.03
90.04	09004	ENT CLINIC	0	569	569	0	569	90.04
90.05	09005	SURGERY CLINIC	0	1,100	1,100	-911	189	90.05
90.07	09007	UROLOGY CLINIC	0	4,655	4,655	-3,740	915	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	3,537	7,330	10,867	2,275	13,142	90.09
90.11	09011	NEUROLOGY CLINIC	0	1,846	1,846	0	1,846	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	49,528	49,528	-41,521	8,007	90.12
90.13	09013	ALLERGY CLINIC	98,190	36,538	134,728	794	135,522	90.13
90.14	09014	WOUND CARE	296,803	218,287	515,090	-44,718	470,372	90.14
91.00	09100	EMERGENCY	2,198,401	2,378,497	4,576,898	-215,307	4,361,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,366,608	386,015	1,752,623	-108,226	1,644,397	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,788,767	55,791,504	82,580,271	-1,818,426	80,761,845	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,135,824	6,818,347	21,954,171	1,818,254	23,772,425	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	0	194.01
194.02	07952	BOUTIQUE SERVICES	38,572	108,900	147,472	172	147,644	194.02
194.03	07953	RETAIL PHARMACY	119,919	1,131,504	1,251,423	0	1,251,423	194.03
200.00		TOTAL (SUM OF LINES 118-199)	42,083,082	63,850,255	105,933,337	0	105,933,337	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-2,146,772	137,998		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,714,603		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,549,420	6,195,630		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,661,554	17,301,160		5.00
7.00	00700	OPERATION OF PLANT	0	2,922,154		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	261,749		8.00
9.00	00900	HOUSEKEEPING	0	530,144		9.00
10.00	01000	DIETARY	-293,025	363,934		10.00
11.00	01100	CAFETERIA	0	732,827		11.00
13.00	01300	NURSING ADMINISTRATION	0	522,163		13.00
15.00	01500	PHARMACY	-13,856	1,177,903		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-857	1,230,809		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,456,956		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,234,445		31.00
40.00	04000	SUBPROVIDER - IPF	-34,231	1,364,866		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	4,040		43.00
44.00	04400	SKILLED NURSING FACILITY	0	769,016		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-833,000	2,736,567		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-101	3,335,778		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	393,497		55.01
57.00	05700	CT SCAN	0	625,042		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	832,052		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	465,854		59.00
60.00	06000	LABORATORY	-251,000	4,818,690		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	36,425		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	1,337,638		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	344,839		67.00
67.01	06701	AUDIOLOGY	-208,505	151,634		67.01
68.00	06800	SPEECH PATHOLOGY	0	89,003		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	901,805		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-140,098	2,009,355		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,664,266		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,023,179		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	305,171		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	-1,684	0		90.03
90.04	09004	ENT CLINIC	0	569		90.04
90.05	09005	SURGERY CLINIC	-189	0		90.05
90.07	09007	UROLOGY CLINIC	-915	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	-13,142	0		90.09
90.11	09011	NEUROLOGY CLINIC	-1,846	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	-8,007	0		90.12
90.13	09013	ALLERGY CLINIC	0	135,522		90.13
90.14	09014	WOUND CARE	0	470,372		90.14
91.00	09100	EMERGENCY	-1,577,190	2,784,401		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,280	1,643,117		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,736,672	68,025,173		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,772,425		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	0		194.01
194.02	07952	BOUTIQUE SERVICES	0	147,644		194.02
194.03	07953	RETAIL PHARMACY	0	1,251,423		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-12,736,672	93,196,665		200.00

RECLASSIFICATIONS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 2:21 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	193,107	1.00
	TOTALS		0	193,107	
	B - INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	184,812	1.00
	TOTALS		0	184,812	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	319,351	413,476	1.00
	TOTALS		319,351	413,476	
	D - MME DEPRECIATION				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,714,603	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
	TOTALS		0	2,714,603	
	E - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,057,342	1.00
	TOTALS		0	1,057,342	
	F - MED SUPPLY IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,664,266	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	2,664,266	
	G - CHARGABLE MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,151,281	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	718	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00

RECLASSIFICATIONS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 2:21 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	2,151,999	
	H - BONUS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	6,276	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	340,456	0	2.00
3.00	OPERATION OF PLANT	7.00	13,590	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	545	0	4.00
5.00	HOUSEKEEPING	9.00	8,434	0	5.00
6.00	DIETARY	10.00	14,755	0	6.00
7.00	NURSING ADMINISTRATION	13.00	11,061	0	7.00
8.00	PHARMACY	15.00	9,964	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	18,337	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	62,847	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	20,672	0	11.00
12.00	SUBPROVIDER - IPF	40.00	22,958	0	12.00
13.00	OPERATING ROOM	50.00	44,310	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	35,814	0	14.00
15.00	ULTRA SOUND	55.01	5,242	0	15.00
16.00	CT SCAN	57.00	3,751	0	16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	6,477	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	3,979	0	18.00
19.00	LABORATORY	60.00	42,409	0	19.00
20.00	PHYSICAL THERAPY	66.00	24,372	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	5,402	0	21.00
22.00	AUDIOLOGY	67.01	3,683	0	22.00
23.00	SPEECH PATHOLOGY	68.00	1,517	0	23.00
24.00	CARDIOLOGY	69.01	15,519	0	24.00
25.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	4,562	0	25.00
26.00	GASTROENTEROLOGY CLINIC	90.09	2,275	0	26.00
27.00	ALLERGY CLINIC	90.13	1,776	0	27.00
28.00	WOUND CARE	90.14	5,555	0	28.00
29.00	EMERGENCY	91.00	44,655	0	29.00
30.00	AMBULANCE SERVICES	95.00	30,564	0	30.00
31.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,977,301	0	31.00
32.00	BOUTIQUE SERVICES	194.02	615	0	32.00
33.00	SKILLED NURSING FACILITY	44.00	2,616	0	33.00
	TOTALS		2,792,289	0	
500.00	Grand Total: Increases		3,111,640	9,379,605	500.00

RECLASSIFICATIONS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 2:21 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	193,107	0		1.00
	TOTALS		0	193,107			
	B - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	184,812	12		1.00
	TOTALS		0	184,812			
	C - CAFETERIA						
1.00	DIETARY	10.00	319,351	413,476	0		1.00
	TOTALS		319,351	413,476			
	D - MME DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	5,473	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,087	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	1,039,411	0		3.00
4.00	OPERATION OF PLANT	7.00	0	74,592	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	68	0		5.00
6.00	HOUSEKEEPING	9.00	0	1,524	0		6.00
7.00	DIETARY	10.00	0	4,507	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	29,790	0		8.00
9.00	PHARMACY	15.00	0	2,788	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,802	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	82,881	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	24,947	0		12.00
13.00	SUBPROVIDER - IPF	40.00	0	1,943	0		13.00
14.00	SKILLED NURSING FACILITY	44.00	0	49,434	0		14.00
15.00	OPERATING ROOM	50.00	0	215,739	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	99,850	0		16.00
17.00	ULTRA SOUND	55.01	0	2,541	0		17.00
18.00	CT SCAN	57.00	0	712	0		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	280,003	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	121,091	0		20.00
21.00	LABORATORY	60.00	0	189,799	0		21.00
23.00	PHYSICAL THERAPY	66.00	0	15,861	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	16,753	0		24.00
25.00	SPEECH PATHOLOGY	68.00	0	64	0		25.00
26.00	CARDIOLOGY	69.01	0	41,737	0		26.00
27.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33	0		27.00
28.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	6,337	0		28.00
30.00	SURGERY CLINIC	90.05	0	911	0		30.00
31.00	UROLOGY CLINIC	90.07	0	3,733	0		31.00
33.00	OPTHAMOLOGY CLINIC	90.12	0	41,521	0		33.00
34.00	ALLERGY CLINIC	90.13	0	956	0		34.00
35.00	WOUND CARE	90.14	0	6,539	0		35.00
36.00	EMERGENCY	91.00	0	56,499	0		36.00
37.00	AMBULANCE SERVICES	95.00	0	132,825	0		37.00
38.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	155,409	0		38.00
39.00	BOUTIQUE SERVICES	194.02	0	443	0		39.00
	TOTALS		0	2,714,603			
	E - DRUGS						
1.00	PHARMACY	15.00	0	1,057,342	0		1.00
	TOTALS		0	1,057,342			
	F - MED SUPPLY IMPLANTS						
1.00	ADULTS & PEDIATRICS	30.00	0	186	0		1.00
2.00	OPERATING ROOM	50.00	0	2,476,269	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,984	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	99,564	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,520	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	34,163	0		6.00
7.00	WOUND CARE	90.14	0	29,580	0		7.00
	TOTALS		0	2,664,266			
	G - CHARGABLE MED SUPPLIES						
1.00	PHARMACY	15.00	0	3,049	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	97,936	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	48,594	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	5,836	0		4.00
5.00	OPERATING ROOM	50.00	0	1,748,959	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,076	0		6.00
7.00	ULTRA SOUND	55.01	0	1,069	0		7.00
8.00	CT SCAN	57.00	0	3,300	0		8.00

RECLASSIFICATIONS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 2:21 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	497	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	2,756	0		10.00
11.00	LABORATORY	60.00	0	1,435	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	1,054	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	8	0		13.00
14.00	CARDIOLOGY	69.01	0	1,487	0		14.00
16.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	1,313	0		16.00
17.00	UROLOGY CLINIC	90.07	0	7	0		17.00
18.00	ALLERGY CLINIC	90.13	0	26	0		18.00
19.00	WOUND CARE	90.14	0	14,154	0		19.00
20.00	EMERGENCY	91.00	0	203,463	0		20.00
21.00	AMBULANCE SERVICES	95.00	0	5,965	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,638	0		22.00
23.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	27	0		23.00
24.00	SKILLED NURSING FACILITY	44.00	0	6,350	0		24.00
	TOTALS		0	2,151,999			
	H - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,792,289	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
	TOTALS		0	2,792,289			
500.00	Grand Total: Decreases		319,351	12,171,894			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I Date/Time Prepared: 5/24/2016 2:21 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	12,992,304	2,088,900	0	2,088,900	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	80,199,727	2,952,480	0	2,952,480	0	3.00
4.00	Building Improvements	2,017,431	4,600,527	0	4,600,527	6,475,016	4.00
5.00	Fixed Equipment	42,404,560	4,829,502	0	4,829,502	102,782	5.00
6.00	Movable Equipment	2,240,495	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139,854,517	14,471,409	0	14,471,409	6,577,798	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	139,854,517	14,471,409	0	14,471,409	6,577,798	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,081,204	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	83,152,207	0	3.00
4.00	Building Improvements	142,942	0	4.00
5.00	Fixed Equipment	47,131,280	0	5.00
6.00	Movable Equipment	2,240,495	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	147,748,128	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	147,748,128	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2016 2:21 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	NEW CAP REL COSTS-BLDG & FIXT	2,105,431	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,105,431	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,105,431		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,105,431		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2016 2:21 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	83,152,207	0	83,152,207	0.973762	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,240,495	0	2,240,495	0.026238	0	2.00
3.00	Total (sum of lines 1-2)	85,392,702	0	85,392,702	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,099,958	-86,519	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,714,603	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,814,561	-86,519	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-2,060,253	184,812	0	0	137,998	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,714,603	2.00
3.00	Total (sum of lines 1-2)	-2,060,253	184,812	0	0	2,852,601	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/24/2016 2:21 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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)	B	-5,106	ADMINISTRATIVE & GENERAL	5.00	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	-2,695,421			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-241,790	DIETARY	10.00	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	B	-2,229	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/24/2016 2:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	HOSPITAL ADMINISTRAT SPONSORSHIPS/DO	A	-121,735	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CICOA MEAL VOUCHERS	B	-3,881	DIETARY	10.00	0	33.01
33.02	LEASE INCOME	B	-41,777	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	RENTAL REVENUE	B	-34,542	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.03
33.04	MEDICAL STAFF FEES	B	-3,200	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PATIENT ACCOUNTS	B	-1,753	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MISC INCOME RECEIVED	B	-318	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MEALS ON WHEELS	B	-33,731	DIETARY	10.00	0	33.07
33.08	MEDICAL RECORDS	B	-857	MEDICAL RECORDS & LIBRARY	16.00	0	33.08
33.09	DERMATOLOGY CLINIC RENT	A	-1,684	DERMATOLOGY CLINIC	90.03	0	33.09
33.10	SURGERY CLINIC RENT	A	-189	SURGERY CLINIC	90.05	0	33.10
33.11			0		0.00	0	33.11
33.12	UROLOGY CLINIC RENT	A	-915	UROLOGY CLINIC	90.07	0	33.12
33.13	GASTROENTEROLOGY CLINIC RENT	A	-13,142	GASTROENTEROLOGY CLINIC	90.09	0	33.13
33.14	NEUROLOGY CLINIC RENT	A	-1,846	NEUROLOGY CLINIC	90.11	0	33.14
33.15	OPTHAMOLOGY CLINIC RENT	A	-8,007	OPTHAMOLOGY CLINIC	90.12	0	33.15
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18	AMBULANCE	B	-1,280	AMBULANCE SERVICES	95.00	0	33.18
33.19	CENTRAL SUPPLY PURCHASING DISCOUNTS	B	-140,098	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.19
33.20	RADIOLOGY DIAGNOSTIC-PURCHASING DISC	B	-101	RADIOLOGY-DIAGNOSTIC	54.00	0	33.20
33.21	PHARMACY ED	B	-13,856	PHARMACY	15.00	0	33.21
33.22			0		0.00	0	33.22
33.23			0		0.00	0	33.23
33.24	EDCUATION REVENUE	B	-2,325	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	HEAD START	B	-11,394	DIETARY	10.00	0	33.25
33.26	WELLNESS REVENUE	B	-59,041	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	1208 N LEBANON RENTAL INCOME	B	-10,200	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.27
33.28	2005 PREMIUM AMORTIZATION	B	-1,700,602	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.28
33.29	2010 PREMIUM AMORTIZATION	B	-24,133	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.29
33.30	2005 BOND GAIN/LOSS ON INVESTMENT	B	-7,755	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.30
33.31	2005 BOND INTEREST ON INVEST	B	-19,013	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.31
33.32	2010 BOND INTEREST ON INVEST	B	-824	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.32
33.33	2015 BOND INTEREST ON INVEST	B	-365	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.33
33.34	INTEREST INCOME - UNNECESSARY BORROW	B	-810,821	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.34
33.35	GAIN ON INVESTMENT	B	503,260	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.35
33.36	GAIN/(LOSS) SHO INV	B	-36,722	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	GAIN/(LOSS) CIHA	B	172,997	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	GAIN/(LOSS) SHO SPC	B	-91,594	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	GAIN/(LOSS) SHO RRG	B	-2,661	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	HEARING AID COSTS	A	-208,505	AUDIOLOGY	67.01	0	33.40
33.41	BANK FEES	A	-177,155	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	LOBBYING EXPENSE-IHHA DUES	A	-1,493	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	LOBBYING EXPENSE-AHA DUES	A	-4,109	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	NON-REIMBURSABLE ADVERTISING COSTS	A	-469,854	ADMINISTRATIVE & GENERAL	5.00	0	33.44
33.45	SELF INSURANCE CLAIMS PAID	B	-4,490,379	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.45
33.46	HAF FEE	A	-1,813,971	ADMINISTRATIVE & GENERAL	5.00	0	33.46
33.47	EMPLOYEE HEALTH REV CLIENT	B	-102,555	ADMINISTRATIVE & GENERAL	5.00	0	33.47
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,736,672				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.

ADJUSTMENTS TO EXPENSES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/24/2016 2:21 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

(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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2016 2:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	SUBPROVIDER - IPF	120,000	0	120,000	181,300	984	1.00
2.00	50.00	OPERATING ROOM	833,000	833,000	0	0	0	2.00
3.00	60.00	LABORATORY	251,000	251,000	0	0	0	3.00
4.00	91.00	EMERGENCY	300,000	300,000	0	0	0	4.00
5.00	91.00	EMERGENCY	1,277,190	1,227,190	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,781,190	2,611,190	120,000		984	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	40.00	SUBPROVIDER - IPF	85,769	4,288	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			85,769	4,288	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	SUBPROVIDER - IPF	0	85,769	34,231	34,231		1.00
2.00	50.00	OPERATING ROOM	0	0	0	833,000		2.00
3.00	60.00	LABORATORY	0	0	0	251,000		3.00
4.00	91.00	EMERGENCY	0	0	0	300,000		4.00
5.00	91.00	EMERGENCY	0	0	0	1,277,190		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	85,769	34,231	2,695,421		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	137,998	137,998				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,714,603		2,714,603			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,195,630	314	6,174	6,202,118		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,301,160	10,030	197,305	796,678	18,305,173	5.00
7.00	00700	OPERATION OF PLANT	2,922,154	13,140	258,490	59,745	3,253,529	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	261,749	0	0	3,214	264,963	8.00
9.00	00900	HOUSEKEEPING	530,144	1,513	29,765	50,242	611,664	9.00
10.00	01000	DIETARY	363,934	3,387	66,627	51,340	485,288	10.00
11.00	01100	CAFETERIA	732,827	0	0	44,741	777,568	11.00
13.00	01300	NURSING ADMINISTRATION	522,163	0	0	67,214	589,377	13.00
15.00	01500	PHARMACY	1,177,903	1,046	20,568	59,394	1,258,911	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,230,809	1,652	32,492	133,138	1,398,091	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,456,956	10,986	216,112	382,427	4,066,481	30.00
31.00	03100	INTENSIVE CARE UNIT	1,234,445	3,017	59,350	134,315	1,431,127	31.00
40.00	04000	SUBPROVIDER - IPF	1,364,866	3,454	67,953	161,722	1,597,995	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	4,040	0	0	0	4,040	43.00
44.00	04400	SKILLED NURSING FACILITY	769,016	2,616	51,458	80,532	903,622	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,736,567	8,768	172,482	271,350	3,189,167	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,335,778	10,724	210,946	154,007	3,711,455	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	393,497	0	0	40,553	434,050	55.01
57.00	05700	CT SCAN	625,042	0	0	15,315	640,357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	832,052	920	18,097	43,608	894,677	58.00
59.00	05900	CARDIAC CATHETERIZATION	465,854	775	15,254	23,837	505,720	59.00
60.00	06000	LABORATORY	4,818,690	5,001	98,376	274,364	5,196,431	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	36,425	0	0	0	36,425	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,337,638	4,840	95,215	154,076	1,591,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	344,839	0	0	45,874	390,713	67.00
67.01	06701	AUDIOLOGY	151,634	0	0	22,637	174,271	67.01
68.00	06800	SPEECH PATHOLOGY	89,003	0	0	11,306	100,309	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	901,805	499	9,812	107,453	1,019,569	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,009,355	0	0	0	2,009,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,664,266	0	0	0	2,664,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,023,179	0	0	0	1,023,179	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	305,171	2,061	40,543	26,024	373,799	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	569	0	0	0	569	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	814	814	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	135,522	0	0	14,005	149,527	90.13
90.14	09014	WOUND CARE	470,372	1,890	37,170	42,360	551,792	90.14
91.00	09100	EMERGENCY	2,784,401	13,247	260,591	314,250	3,372,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,643,117	2,567	50,493	195,742	1,891,919	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,025,173	102,447	2,015,273	3,782,277	64,870,451	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	336	6,619	0	6,955	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,772,425	23,157	455,521	2,397,550	26,648,653	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	764	15,021	0	15,785	194.01
194.02	07952	BOUTIQUE SERVICES	147,644	11,078	217,926	5,490	382,138	194.02
194.03	07953	RETAIL PHARMACY	1,251,423	216	4,243	16,801	1,272,683	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/24/2016 2:21 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
202.00	TOTAL (sum lines 118-201)	93,196,665	137,998	2,714,603	6,202,118	93,196,665	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 2:21 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,305,173					5.00
7.00	00700	OPERATION OF PLANT	795,237	4,048,766				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,763	0	329,726			8.00
9.00	00900	HOUSEKEEPING	149,505	61,806	0	822,975		9.00
10.00	01000	DIETARY	118,616	138,349	0	51,027	793,280	10.00
11.00	01100	CAFETERIA	190,056	0	0	17,013	0	11.00
13.00	01300	NURSING ADMINISTRATION	144,057	0	0	7,693	0	13.00
15.00	01500	PHARMACY	307,707	42,709	0	15,534	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	341,726	67,467	0	34,026	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	993,941	448,747	16,935	258,486	356,910	30.00
31.00	03100	INTENSIVE CARE UNIT	349,800	123,239	4,006	68,644	111,303	31.00
40.00	04000	SUBPROVIDER - IPF	390,587	141,102	3,649	81,627	201,309	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	987	0	1,822	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	220,866	106,851	1,029	0	123,758	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	779,506	358,152	49,045	15,238	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	907,165	438,020	26,241	68,940	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	106,092	0	9,458	4,438	0	55.01
57.00	05700	CT SCAN	156,518	0	38,778	6,805	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218,680	37,577	16,189	6,509	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	123,610	31,674	3,343	0	0	59.00
60.00	06000	LABORATORY	1,270,127	204,274	55,714	29,144	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,903	0	946	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	2,813	0	0	64.00
66.00	06600	PHYSICAL THERAPY	389,065	197,710	7,653	10,504	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,499	0	1,798	5,030	0	67.00
67.01	06701	AUDIOLOGY	42,596	0	1,042	3,698	0	67.01
68.00	06800	SPEECH PATHOLOGY	24,518	0	551	2,219	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	249,206	20,375	12,219	22,339	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	491,133	0	5,868	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	651,208	0	7,410	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,088	0	15,746	16,125	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	91,365	84,185	0	39,648	0	90.01
90.02	09002	CLINIC	0	0	0	58,288	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	139	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	147	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	199	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	771	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	36,548	0	801	0	0	90.13
90.14	09014	WOUND CARE	134,871	77,181	3,038	0	0	90.14
91.00	09100	EMERGENCY	824,314	541,104	35,126	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	462,429	38,767	7,588	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,381,627	3,159,289	329,726	822,975	793,280	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,700	13,745	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,513,512	835,731	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	3,858	31,190	0	0	0	194.01
194.02	07952	BOUTIQUE SERVICES	93,403	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	311,073	8,811	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	18,305,173	4,048,766	329,726	822,975	793,280	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	984,637					11.00
13.00	01300	NURSING ADMINISTRATION	19,051	760,178				13.00
15.00	01500	PHARMACY	38,102	0	1,662,963			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,207	0	0	1,918,517		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	259,696	168,864	4,896	471,460	7,046,416	30.00
31.00	03100	INTENSIVE CARE UNIT	21,056	47,902	212	98,026	2,255,315	31.00
40.00	04000	SUBPROVIDER - IPF	33,089	85,962	89	116,698	2,652,107	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	6,849	43.00
44.00	04400	SKILLED NURSING FACILITY	0	8,228	125	0	1,364,479	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,062	134,147	15,451	169,212	4,732,980	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,075	0	8,074	452,789	5,640,759	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	3,008	0	1,194	49,013	607,253	55.01
57.00	05700	CT SCAN	4,011	0	2,904	56,015	905,388	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,027	0	5,232	30,342	1,219,233	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,401	16	0	672,764	59.00
60.00	06000	LABORATORY	82,220	0	220	46,679	6,884,809	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	46,274	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	2,813	64.00
66.00	06600	PHYSICAL THERAPY	41,110	57,432	5,540	91,025	2,391,808	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,046	17,034	1,418	39,677	568,215	67.00
67.01	06701	AUDIOLOGY	18,048	11,790	0	0	251,445	67.01
68.00	06800	SPEECH PATHOLOGY	19,051	3,425	0	0	150,073	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	41,110	48,409	516	87,524	1,501,267	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,056	0	0	0	2,527,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,322,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,305,138	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	34,091	10,385	264	196,053	829,790	90.01
90.02	09002	CLINIC	0	0	0	0	58,288	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	708	90.04
90.05	09005	SURGERY CLINIC	0	0	27	0	27	90.05
90.07	09007	UROLOGY CLINIC	0	0	671	0	818	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	9,683	0	0	10,696	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	322	0	1,093	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	6,091	2,486	0	195,453	90.13
90.14	09014	WOUND CARE	0	14,622	9,711	0	791,215	90.14
91.00	09100	EMERGENCY	64,172	124,322	55,023	0	5,016,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	130,349	0	16,195	0	2,547,247	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	984,637	756,697	130,586	1,904,513	55,507,566	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	22,400	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,554	1,532,377	14,004	35,546,831	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	927	0	0	927	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	50,833	194.01
194.02	07952	BOUTIQUE SERVICES	0	0	0	0	475,541	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	1,592,567	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	984,637	760,178	1,662,963	1,918,517	93,196,665	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,046,416		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,255,315		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,652,107		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	6,849		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,364,479		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,732,980		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,640,759		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	607,253		55.01
57.00	05700	CT SCAN	0	905,388		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,219,233		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	672,764		59.00
60.00	06000	LABORATORY	0	6,884,809		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	46,274		63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,813		64.00
66.00	06600	PHYSICAL THERAPY	0	2,391,808		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	568,215		67.00
67.01	06701	AUDIOLOGY	0	251,445		67.01
68.00	06800	SPEECH PATHOLOGY	0	150,073		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	1,501,267		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,527,412		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,322,884		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,305,138		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	829,790		90.01
90.02	09002	CLINIC	0	58,288		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	708		90.04
90.05	09005	SURGERY CLINIC	0	27		90.05
90.07	09007	UROLOGY CLINIC	0	818		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	10,696		90.09
90.11	09011	NEUROLOGY CLINIC	0	1,093		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	195,453		90.13
90.14	09014	WOUND CARE	0	791,215		90.14
91.00	09100	EMERGENCY	0	5,016,550		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,547,247		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	55,507,566		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	22,400		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	35,546,831		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	927		194.00
194.01	07951	CAFE/BOUTIQUE	0	50,833		194.01
194.02	07952	BOUTIQUE SERVICES	0	475,541		194.02
194.03	07953	RETAIL PHARMACY	0	1,592,567		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	93,196,665		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	314	6,174	6,488	6,488	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	10,030	197,305	207,335	836	5.00
7.00	00700	OPERATION OF PLANT	0	13,140	258,490	271,630	63	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	3	8.00
9.00	00900	HOUSEKEEPING	0	1,513	29,765	31,278	53	9.00
10.00	01000	DIETARY	0	3,387	66,627	70,014	54	10.00
11.00	01100	CAFETERIA	0	0	0	0	47	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	71	13.00
15.00	01500	PHARMACY	0	1,046	20,568	21,614	62	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,652	32,492	34,144	140	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	10,986	216,112	227,098	401	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,017	59,350	62,367	141	31.00
40.00	04000	SUBPROVIDER - IPF	0	3,454	67,953	71,407	170	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,616	51,458	54,074	84	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,768	172,482	181,250	285	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,724	210,946	221,670	162	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	43	55.01
57.00	05700	CT SCAN	0	0	0	0	16	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	920	18,097	19,017	46	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	775	15,254	16,029	25	59.00
60.00	06000	LABORATORY	0	5,001	98,376	103,377	288	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	4,840	95,215	100,055	162	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	48	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	24	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	12	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	499	9,812	10,311	113	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	2,061	40,543	42,604	27	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	1	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	15	90.13
90.14	09014	WOUND CARE	0	1,890	37,170	39,060	44	90.14
91.00	09100	EMERGENCY	0	13,247	260,591	273,838	330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,567	50,493	53,060	205	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	102,447	2,015,273	2,117,720	3,971	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	336	6,619	6,955	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,157	455,521	478,678	2,493	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	764	15,021	15,785	0	194.01
194.02	07952	BOUTIQUE SERVICES	0	11,078	217,926	229,004	6	194.02
194.03	07953	RETAIL PHARMACY	0	216	4,243	4,459	18	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	137,998	2,714,603	2,852,601	6,488	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/24/2016 2:21 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	208,171					5.00
7.00	00700	OPERATION OF PLANT	9,045	280,738				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	737	0	740			8.00
9.00	00900	HOUSEKEEPING	1,700	4,286	0	37,317		9.00
10.00	01000	DIETARY	1,349	9,593	0	2,314	83,324	10.00
11.00	01100	CAFETERIA	2,162	0	0	771	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,638	0	0	349	0	13.00
15.00	01500	PHARMACY	3,500	2,961	0	704	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,887	4,678	0	1,543	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,305	31,116	42	11,720	37,489	30.00
31.00	03100	INTENSIVE CARE UNIT	3,979	8,545	10	3,113	11,691	31.00
40.00	04000	SUBPROVIDER - IPF	4,442	9,784	9	3,701	21,145	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	11	0	4	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,512	7,409	3	0	12,999	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,866	24,834	121	691	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,318	30,372	65	3,126	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	1,207	0	23	201	0	55.01
57.00	05700	CT SCAN	1,780	0	96	309	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,487	2,606	40	295	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,406	2,196	8	0	0	59.00
60.00	06000	LABORATORY	14,446	14,164	65	1,322	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	101	0	2	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	7	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,425	13,709	19	476	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,086	0	4	228	0	67.00
67.01	06701	AUDIOLOGY	484	0	3	168	0	67.01
68.00	06800	SPEECH PATHOLOGY	279	0	1	101	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	2,834	1,413	30	1,013	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,586	0	14	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,407	0	18	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,844	0	39	731	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	1,039	5,837	0	1,798	0	90.01
90.02	09002	CLINIC	0	0	0	2,643	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	2	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	2	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	2	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	416	0	2	0	0	90.13
90.14	09014	WOUND CARE	1,534	5,352	7	0	0	90.14
91.00	09100	EMERGENCY	9,376	37,520	87	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,260	2,688	19	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	129,452	219,063	740	37,317	83,324	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19	953	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	74,056	57,948	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	44	2,163	0	0	0	194.01
194.02	07952	BOUTIQUE SERVICES	1,062	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	3,538	611	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	208,171	280,738	740	37,317	83,324	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	2,980					11.00
13.00	01300	NURSING ADMINISTRATION	58	2,116				13.00
15.00	01500	PHARMACY	115	0	28,956			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	234	0	0	44,626		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	785	470	85	10,967	331,478	30.00
31.00	03100	INTENSIVE CARE UNIT	64	133	4	2,280	92,327	31.00
40.00	04000	SUBPROVIDER - IPF	100	239	2	2,714	113,713	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	15	43.00
44.00	04400	SKILLED NURSING FACILITY	0	23	2	0	77,106	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	70	373	269	3,936	220,695	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85	0	141	10,532	276,471	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	9	0	21	1,140	2,644	55.01
57.00	05700	CT SCAN	12	0	51	1,303	3,567	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	30	0	91	706	25,318	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	23	0	0	19,687	59.00
60.00	06000	LABORATORY	249	0	4	1,086	135,001	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	103	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	7	64.00
66.00	06600	PHYSICAL THERAPY	124	160	96	2,117	121,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	52	47	25	923	2,413	67.00
67.01	06701	AUDIOLOGY	55	33	0	0	767	67.01
68.00	06800	SPEECH PATHOLOGY	58	10	0	0	461	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	124	135	9	2,036	18,018	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	64	0	0	0	5,664	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	7,425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,614	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	103	29	5	4,560	56,002	90.01
90.02	09002	CLINIC	0	0	0	0	2,643	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	2	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	12	0	12	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	27	0	0	30	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	6	0	8	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	17	43	0	493	90.13
90.14	09014	WOUND CARE	0	41	169	0	46,207	90.14
91.00	09100	EMERGENCY	194	346	958	0	322,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	395	0	282	0	61,909	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,980	2,106	2,275	44,300	1,947,792	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	7,927	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7	26,681	326	640,189	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	3	0	0	3	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	17,992	194.01
194.02	07952	BOUTIQUE SERVICES	0	0	0	0	230,072	194.02
194.03	07953	RETAIL PHARMACY	0	0	0	0	8,626	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,980	2,116	28,956	44,626	2,852,601	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	331,478		30.00
31.00	03100	INTENSIVE CARE UNIT	0	92,327		31.00
40.00	04000	SUBPROVIDER - IPF	0	113,713		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	15		43.00
44.00	04400	SKILLED NURSING FACILITY	0	77,106		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	220,695		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	276,471		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	2,644		55.01
57.00	05700	CT SCAN	0	3,567		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	25,318		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,687		59.00
60.00	06000	LABORATORY	0	135,001		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	103		63.00
64.00	06400	INTRAVENOUS THERAPY	0	7		64.00
66.00	06600	PHYSICAL THERAPY	0	121,343		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,413		67.00
67.01	06701	AUDIOLOGY	0	767		67.01
68.00	06800	SPEECH PATHOLOGY	0	461		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	18,018		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,664		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,425		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,614		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	56,002		90.01
90.02	09002	CLINIC	0	2,643		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	2		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	12		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	30		90.09
90.11	09011	NEUROLOGY CLINIC	0	8		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	493		90.13
90.14	09014	WOUND CARE	0	46,207		90.14
91.00	09100	EMERGENCY	0	322,649		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	61,909		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,947,792		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	7,927		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	640,189		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	3		194.00
194.01	07951	CAFE/BOUTIQUE	0	17,992		194.01
194.02	07952	BOUTIQUE SERVICES	0	230,072		194.02
194.03	07953	RETAIL PHARMACY	0	8,626		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	2,852,601		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	255,907					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		255,907				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	582	582	44,269,432			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,600	18,600	5,686,535	-18,305,173	74,891,492	5.00
7.00	00700	OPERATION OF PLANT	24,368	24,368	426,451	0	3,253,529	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	22,943	0	264,963	8.00
9.00	00900	HOUSEKEEPING	2,806	2,806	358,620	0	611,664	9.00
10.00	01000	DIETARY	6,281	6,281	366,455	0	485,288	10.00
11.00	01100	CAFETERIA	0	0	319,351	0	777,568	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	479,759	0	589,377	13.00
15.00	01500	PHARMACY	1,939	1,939	423,944	0	1,258,911	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	3,063	950,315	0	1,398,091	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	20,373	2,729,689	0	4,066,481	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	5,595	958,712	0	1,431,127	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	6,406	1,154,342	0	1,597,995	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	4,040	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	4,851	574,822	0	903,622	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	16,260	1,936,847	0	3,189,167	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	19,886	1,099,274	0	3,711,455	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	289,461	0	434,050	55.01
57.00	05700	CT SCAN	0	0	109,319	0	640,357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	1,706	311,266	0	894,677	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	1,438	170,147	0	505,720	59.00
60.00	06000	LABORATORY	9,274	9,274	1,958,357	0	5,196,431	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	36,425	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,976	1,099,765	0	1,591,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	327,442	0	390,713	67.00
67.01	06701	AUDIOLOGY	0	0	161,582	0	174,271	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	80,702	0	100,309	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	925	766,982	0	1,019,569	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,009,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,664,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,023,179	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	3,822	185,755	0	373,799	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	569	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	5,812	0	814	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	99,966	0	149,527	90.13
90.14	09014	WOUND CARE	3,504	3,504	302,358	0	551,792	90.14
91.00	09100	EMERGENCY	24,566	24,566	2,243,056	0	3,372,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,760	4,760	1,397,172	0	1,891,919	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	189,981	189,981	26,997,201	-18,305,173	46,565,278	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	6,955	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,942	42,942	17,113,125	0	26,648,653	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	1,416	0	0	15,785	194.01
194.02	07952	BOUTIQUE SERVICES	20,544	20,544	39,187	0	382,138	194.02
194.03	07953	RETAIL PHARMACY	400	400	119,919	0	1,272,683	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	137,998	2,714,603	6,202,118		18,305,173	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.539251	10.607772	0.140099		0.244423	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,488		208,171	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000147		0.002780	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	183,813					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	270,648,601				8.00
9.00	00900	HOUSEKEEPING	2,806	0	139,073			9.00
10.00	01000	DIETARY	6,281	0	8,623	38,216		10.00
11.00	01100	CAFETERIA	0	0	2,875	0	982	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,300	0	19	13.00
15.00	01500	PHARMACY	1,939	0	2,625	0	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	0	5,750	0	77	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	13,903,951	43,681	17,194	259	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	3,288,647	11,600	5,362	21	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	2,995,813	13,794	9,698	33	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,495,885	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851	845,064	0	5,962	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	40,267,212	2,575	0	23	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	21,543,930	11,650	0	28	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	7,764,835	750	0	3	55.01
57.00	05700	CT SCAN	0	31,837,395	1,150	0	4	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	13,291,629	1,100	0	10	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	2,744,799	0	0	0	59.00
60.00	06000	LABORATORY	9,274	45,678,919	4,925	0	82	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	776,767	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,309,894	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	6,283,193	1,775	0	41	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,476,424	850	0	17	67.00
67.01	06701	AUDIOLOGY	0	855,557	625	0	18	67.01
68.00	06800	SPEECH PATHOLOGY	0	452,639	375	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	10,031,735	3,775	0	41	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,818,011	0	0	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,083,952	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,927,598	2,725	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	0	6,700	0	34	90.01
90.02	09002	CLINIC	0	0	9,850	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	120,547	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	632,649	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	657,576	0	0	0	90.13
90.14	09014	WOUND CARE	3,504	2,494,210	0	0	0	90.14
91.00	09100	EMERGENCY	24,566	28,839,483	0	0	64	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,760	6,230,287	0	0	130	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	143,431	270,648,601	139,073	38,216	982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,942	0	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,416	0	0	0	0	194.01
194.02	07952	BOUTIQUE SERVICES	0	0	0	0	0	194.02
194.03	07953	RETAIL PHARMACY	400	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,048,766	329,726	822,975	793,280	984,637	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.026549	0.001218	5.917576	20.757798	1,002.685336	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 2:21 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	280,738	740	37,317	83,324	2,980	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.527302	0.000003	0.268327	2.180343	3.034623	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	364,031				13.00
15.00	01500	PHARMACY	0	1,676,074			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	41,100		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	80,865	4,935	10,100		30.00
31.00	03100	INTENSIVE CARE UNIT	22,939	214	2,100		31.00
40.00	04000	SUBPROVIDER - IPF	41,165	90	2,500		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	3,940	126	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	64,240	15,573	3,625		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,138	9,700		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	1,203	1,050		55.01
57.00	05700	CT SCAN	0	2,927	1,200		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,273	650		58.00
59.00	05900	CARDIAC CATHETERIZATION	4,023	16	0		59.00
60.00	06000	LABORATORY	0	222	1,000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	27,503	5,584	1,950		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,157	1,429	850		67.00
67.01	06701	AUDIOLOGY	5,646	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	1,640	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	23,182	520	1,875		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	4,973	266	4,200		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	27	0		90.05
90.07	09007	UROLOGY CLINIC	0	676	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	4,637	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	325	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	2,917	2,506	0		90.13
90.14	09014	WOUND CARE	7,002	9,788	0		90.14
91.00	09100	EMERGENCY	59,535	55,457	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	16,323	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	362,364	131,618	40,800		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,223	1,544,456	300		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	444	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0		194.01
194.02	07952	BOUTIQUE SERVICES	0	0	0		194.02
194.03	07953	RETAIL PHARMACY	0	0	0		194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	760,178	1,662,963	1,918,517		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 2:21 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	16.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	2.088223	0.992178	46.679246		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,116	28,956	44,626		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005813	0.017276	1.085791		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,046,416		7,046,416	0	7,046,416	30.00
31.00	03100	INTENSIVE CARE UNIT	2,255,315		2,255,315	0	2,255,315	31.00
40.00	04000	SUBPROVIDER - IPF	2,652,107		2,652,107	34,231	2,686,338	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	6,849		6,849	0	6,849	43.00
44.00	04400	SKILLED NURSING FACILITY	1,364,479		1,364,479	0	1,364,479	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,732,980		4,732,980	0	4,732,980	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,640,759		5,640,759	0	5,640,759	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	607,253		607,253	0	607,253	55.01
57.00	05700	CT SCAN	905,388		905,388	0	905,388	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,219,233		1,219,233	0	1,219,233	58.00
59.00	05900	CARDIAC CATHETERIZATION	672,764		672,764	0	672,764	59.00
60.00	06000	LABORATORY	6,884,809		6,884,809	0	6,884,809	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	46,274		46,274	0	46,274	63.00
64.00	06400	INTRAVENOUS THERAPY	2,813		2,813	0	2,813	64.00
66.00	06600	PHYSICAL THERAPY	2,391,808	0	2,391,808	0	2,391,808	66.00
67.00	06700	OCCUPATIONAL THERAPY	568,215	0	568,215	0	568,215	67.00
67.01	06701	AUDIOLOGY	251,445	0	251,445	0	251,445	67.01
68.00	06800	SPEECH PATHOLOGY	150,073	0	150,073	0	150,073	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,501,267		1,501,267	0	1,501,267	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,527,412		2,527,412	0	2,527,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,322,884		3,322,884	0	3,322,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,305,138		1,305,138	0	1,305,138	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	829,790		829,790	0	829,790	90.01
90.02	09002	CLINIC	58,288		58,288	0	58,288	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	708		708	0	708	90.04
90.05	09005	SURGERY CLINIC	27		27	0	27	90.05
90.07	09007	UROLOGY CLINIC	818		818	0	818	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	10,696		10,696	0	10,696	90.09
90.11	09011	NEUROLOGY CLINIC	1,093		1,093	0	1,093	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	195,453		195,453	0	195,453	90.13
90.14	09014	WOUND CARE	791,215		791,215	0	791,215	90.14
91.00	09100	EMERGENCY	5,016,550		5,016,550	0	5,016,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,331,942		1,331,942		1,331,942	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,547,247		2,547,247	0	2,547,247	95.00
200.00		Subtotal (see instructions)	56,839,508	0	56,839,508	34,231	56,873,739	200.00
201.00		Less Observation Beds	1,331,942		1,331,942		1,331,942	201.00
202.00		Total (see instructions)	55,507,566	0	55,507,566	34,231	55,541,797	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,585,718		11,585,718			30.00
31.00	03100	INTENSIVE CARE UNIT	3,288,647		3,288,647			31.00
40.00	04000	SUBPROVIDER - IPF	2,995,813		2,995,813			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,495,885		1,495,885			43.00
44.00	04400	SKILLED NURSING FACILITY	845,064		845,064			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,780,643	33,486,569	40,267,212	0.117539	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,288,558	20,255,372	21,543,930	0.261826	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	462,527	7,302,308	7,764,835	0.078206	0.000000	55.01
57.00	05700	CT SCAN	3,310,130	28,527,265	31,837,395	0.028438	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	541,646	12,749,983	13,291,629	0.091729	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	895,097	1,849,702	2,744,799	0.245105	0.000000	59.00
60.00	06000	LABORATORY	7,734,786	37,944,133	45,678,919	0.150722	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	411,096	365,671	776,767	0.059573	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,020,929	1,288,965	2,309,894	0.001218	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	1,194,412	5,088,781	6,283,193	0.380668	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	912,143	564,281	1,476,424	0.384859	0.000000	67.00
67.01	06701	AUDIOLOGY	0	855,557	855,557	0.293896	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	92,117	360,522	452,639	0.331551	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	3,797,830	6,233,905	10,031,735	0.149652	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,185,946	2,632,065	4,818,011	0.524576	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,404,398	3,679,554	6,083,952	0.546172	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,409,365	6,518,233	12,927,598	0.100958	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	120,547	120,547	0.006786	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	632,649	632,649	0.001728	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	657,576	657,576	0.297233	0.000000	90.13
90.14	09014	WOUND CARE	5,692	2,488,518	2,494,210	0.317221	0.000000	90.14
91.00	09100	EMERGENCY	3,265,349	25,574,134	28,839,483	0.173947	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,318,233	2,318,233	0.574551	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,570	6,227,717	6,230,287	0.408849	0.000000	95.00
200.00		Subtotal (see instructions)	62,926,361	207,722,240	270,648,601			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	62,926,361	207,722,240	270,648,601			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.117539		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261826		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.078206		55.01
57.00	05700	CT SCAN	0.028438		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091729		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245105		59.00
60.00	06000	LABORATORY	0.150722		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.059573		63.00
64.00	06400	INTRAVENOUS THERAPY	0.001218		64.00
66.00	06600	PHYSICAL THERAPY	0.380668		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384859		67.00
67.01	06701	AUDIOLOGY	0.293896		67.01
68.00	06800	SPEECH PATHOLOGY	0.331551		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.149652		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.524576		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.546172		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100958		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.006786		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.001728		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000		90.12
90.13	09013	ALLERGY CLINIC	0.297233		90.13
90.14	09014	WOUND CARE	0.317221		90.14
91.00	09100	EMERGENCY	0.173947		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.574551		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.408849		95.00
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: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,046,416		7,046,416	0	7,046,416	30.00
31.00	03100	INTENSIVE CARE UNIT	2,255,315		2,255,315	0	2,255,315	31.00
40.00	04000	SUBPROVIDER - IPF	2,652,107		2,652,107	34,231	2,686,338	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	6,849		6,849	0	6,849	43.00
44.00	04400	SKILLED NURSING FACILITY	1,364,479		1,364,479	0	1,364,479	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,732,980		4,732,980	0	4,732,980	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,640,759		5,640,759	0	5,640,759	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	607,253		607,253	0	607,253	55.01
57.00	05700	CT SCAN	905,388		905,388	0	905,388	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,219,233		1,219,233	0	1,219,233	58.00
59.00	05900	CARDIAC CATHETERIZATION	672,764		672,764	0	672,764	59.00
60.00	06000	LABORATORY	6,884,809		6,884,809	0	6,884,809	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	46,274		46,274	0	46,274	63.00
64.00	06400	INTRAVENOUS THERAPY	2,813		2,813	0	2,813	64.00
66.00	06600	PHYSICAL THERAPY	2,391,808	0	2,391,808	0	2,391,808	66.00
67.00	06700	OCCUPATIONAL THERAPY	568,215	0	568,215	0	568,215	67.00
67.01	06701	AUDIOLOGY	251,445	0	251,445	0	251,445	67.01
68.00	06800	SPEECH PATHOLOGY	150,073	0	150,073	0	150,073	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,501,267		1,501,267	0	1,501,267	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,527,412		2,527,412	0	2,527,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,322,884		3,322,884	0	3,322,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,305,138		1,305,138	0	1,305,138	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	829,790		829,790	0	829,790	90.01
90.02	09002	CLINIC	58,288		58,288	0	58,288	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	708		708	0	708	90.04
90.05	09005	SURGERY CLINIC	27		27	0	27	90.05
90.07	09007	UROLOGY CLINIC	818		818	0	818	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	10,696		10,696	0	10,696	90.09
90.11	09011	NEUROLOGY CLINIC	1,093		1,093	0	1,093	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0		0	0	0	90.12
90.13	09013	ALLERGY CLINIC	195,453		195,453	0	195,453	90.13
90.14	09014	WOUND CARE	791,215		791,215	0	791,215	90.14
91.00	09100	EMERGENCY	5,016,550		5,016,550	0	5,016,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,331,942		1,331,942		1,331,942	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,547,247		2,547,247	0	2,547,247	95.00
200.00		Subtotal (see instructions)	56,839,508	0	56,839,508	34,231	56,873,739	200.00
201.00		Less Observation Beds	1,331,942		1,331,942		1,331,942	201.00
202.00		Total (see instructions)	55,507,566	0	55,507,566	34,231	55,541,797	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,585,718		11,585,718			30.00
31.00	03100	INTENSIVE CARE UNIT	3,288,647		3,288,647			31.00
40.00	04000	SUBPROVIDER - IPF	2,995,813		2,995,813			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,495,885		1,495,885			43.00
44.00	04400	SKILLED NURSING FACILITY	845,064		845,064			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,780,643	33,486,569	40,267,212	0.117539	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,288,558	20,255,372	21,543,930	0.261826	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	462,527	7,302,308	7,764,835	0.078206	0.000000	55.01
57.00	05700	CT SCAN	3,310,130	28,527,265	31,837,395	0.028438	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	541,646	12,749,983	13,291,629	0.091729	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	895,097	1,849,702	2,744,799	0.245105	0.000000	59.00
60.00	06000	LABORATORY	7,734,786	37,944,133	45,678,919	0.150722	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	411,096	365,671	776,767	0.059573	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,020,929	1,288,965	2,309,894	0.001218	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	1,194,412	5,088,781	6,283,193	0.380668	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	912,143	564,281	1,476,424	0.384859	0.000000	67.00
67.01	06701	AUDIOLOGY	0	855,557	855,557	0.293896	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	92,117	360,522	452,639	0.331551	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	3,797,830	6,233,905	10,031,735	0.149652	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,185,946	2,632,065	4,818,011	0.524576	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,404,398	3,679,554	6,083,952	0.546172	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,409,365	6,518,233	12,927,598	0.100958	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	120,547	120,547	0.006786	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	632,649	632,649	0.001728	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	657,576	657,576	0.297233	0.000000	90.13
90.14	09014	WOUND CARE	5,692	2,488,518	2,494,210	0.317221	0.000000	90.14
91.00	09100	EMERGENCY	3,265,349	25,574,134	28,839,483	0.173947	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,318,233	2,318,233	0.574551	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,570	6,227,717	6,230,287	0.408849	0.000000	95.00
200.00		Subtotal (see instructions)	62,926,361	207,722,240	270,648,601			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	62,926,361	207,722,240	270,648,601			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.000000		55.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	AUDIOLOGY	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.000000		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.000000		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000		90.12
90.13	09013	ALLERGY CLINIC	0.000000		90.13
90.14	09014	WOUND CARE	0.000000		90.14
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	331,478	0	331,478	5,867	56.50	30.00
31.00	INTENSIVE CARE UNIT	92,327		92,327	1,563	59.07	31.00
40.00	SUBPROVIDER - IPF	113,713	0	113,713	2,827	40.22	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	15		15	1,030	0.01	43.00
44.00	SKILLED NURSING FACILITY	77,106		77,106	1,738	44.36	44.00
200.00	Total (lines 30-199)	614,639		614,639	13,025		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,174	122,831	30.00
31.00	INTENSIVE CARE UNIT	664	39,222	31.00
40.00	SUBPROVIDER - IPF	2,358	94,839	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,350	59,886	44.00
200.00	Total (lines 30-199)	6,546	316,778	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	220,695	40,267,212	0.005481	4,371,437	23,960	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	276,471	21,543,930	0.012833	1,123,078	14,412	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	2,644	7,764,835	0.000341	63,755	22	55.01
57.00	05700	CT SCAN	3,567	31,837,395	0.000112	1,542,321	173	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,318	13,291,629	0.001905	65,043	124	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,687	2,744,799	0.007172	466,561	3,346	59.00
60.00	06000	LABORATORY	135,001	45,678,919	0.002955	4,152,920	12,272	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103	776,767	0.000133	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	7	2,309,894	0.000003	392,245	1	64.00
66.00	06600	PHYSICAL THERAPY	121,343	6,283,193	0.019312	362,638	7,003	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,413	1,476,424	0.001634	175,190	286	67.00
67.01	06701	AUDIOLOGY	767	855,557	0.000896	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	461	452,639	0.001018	33,062	34	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	18,018	10,031,735	0.001796	2,236,147	4,016	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,664	4,818,011	0.001176	908,038	1,068	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,425	6,083,952	0.001220	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,614	12,927,598	0.000280	2,593,362	726	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	56,002	0	0.000000	0	0	90.01
90.02	09002	CLINIC	2,643	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	2	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	12	120,547	0.000100	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	30	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	8	632,649	0.000013	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	493	657,576	0.000750	0	0	90.13
90.14	09014	WOUND CARE	46,207	2,494,210	0.018526	271	5	90.14
91.00	09100	EMERGENCY	322,649	28,839,483	0.011188	1,377,842	15,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,657	2,318,233	0.027028	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,333,901	244,207,187		19,863,910	82,863	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,867	0.00	2,174	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,563	0.00	664	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,827	0.00	2,358	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	1,030	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	1,738	0.00	1,350	0		44.00
200.00		Total (lines 30-199)	13,025		6,546	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	40,267,212	0.000000	0.000000	4,371,437	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,543,930	0.000000	0.000000	1,123,078	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0	7,764,835	0.000000	0.000000	63,755	55.01
57.00	05700	CT SCAN	0	31,837,395	0.000000	0.000000	1,542,321	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,291,629	0.000000	0.000000	65,043	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,744,799	0.000000	0.000000	466,561	59.00
60.00	06000	LABORATORY	0	45,678,919	0.000000	0.000000	4,152,920	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	776,767	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,309,894	0.000000	0.000000	392,245	64.00
66.00	06600	PHYSICAL THERAPY	0	6,283,193	0.000000	0.000000	362,638	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,476,424	0.000000	0.000000	175,190	67.00
67.01	06701	AUDIOLOGY	0	855,557	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	452,639	0.000000	0.000000	33,062	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0	10,031,735	0.000000	0.000000	2,236,147	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,818,011	0.000000	0.000000	908,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,083,952	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,927,598	0.000000	0.000000	2,593,362	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0	120,547	0.000000	0.000000	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	632,649	0.000000	0.000000	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0.000000	0	90.12
90.13	09013	ALLERGY CLINIC	0	657,576	0.000000	0.000000	0	90.13
90.14	09014	WOUND CARE	0	2,494,210	0.000000	0.000000	271	90.14
91.00	09100	EMERGENCY	0	28,839,483	0.000000	0.000000	1,377,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,318,233	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	244,207,187			19,863,910	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	9,247,963	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,154,493	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	1,486,379	0		55.01
57.00	05700	CT SCAN	0	6,753,105	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,945,225	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	705,413	0		59.00
60.00	06000	LABORATORY	0	3,901,764	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	103,902	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	279,147	0		64.00
66.00	06600	PHYSICAL THERAPY	0	2,483	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	06701	AUDIOLOGY	0	122,075	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	0	2,569,508	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	666,625	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	59,776	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,005,331	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	166,175	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	19,960	0		90.13
90.14	09014	WOUND CARE	0	92,715	0		90.14
91.00	09100	EMERGENCY	0	3,868,320	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,059,468	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	44,209,827	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.117539	9,247,963	0	0	1,086,996	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261826	5,154,493	0	0	1,349,580	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.078206	1,486,379	0	0	116,244	55.01
57.00	05700	CT SCAN	0.028438	6,753,105	0	0	192,045	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091729	3,945,225	0	0	361,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245105	705,413	0	0	172,900	59.00
60.00	06000	LABORATORY	0.150722	3,901,764	0	0	588,082	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.059573	103,902	0	0	6,190	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001218	279,147	0	0	340	64.00
66.00	06600	PHYSICAL THERAPY	0.380668	2,483	0	0	945	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384859	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.293896	122,075	0	0	35,877	67.01
68.00	06800	SPEECH PATHOLOGY	0.331551	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.149652	2,569,508	0	0	384,532	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.524576	666,625	0	0	349,695	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.546172	59,776	0	0	32,648	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100958	4,005,331	0	14,313	404,370	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006786	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001728	166,175	0	0	287	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.297233	19,960	0	0	5,933	90.13
90.14	09014	WOUND CARE	0.317221	92,715	0	0	29,411	90.14
91.00	09100	EMERGENCY	0.173947	3,868,320	0	0	672,883	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.574551	1,059,468	0	0	608,718	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.408849		0			95.00
200.00		Subtotal (see instructions)		44,209,827	0	14,313	6,399,568	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		44,209,827	0	14,313	6,399,568	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	55.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,445	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	90.13
90.14	09014	WOUND CARE	0	0	90.14
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	1,445	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,445	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	220,695	40,267,212	0.005481	565	3	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	276,471	21,543,930	0.012833	77,404	993	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	2,644	7,764,835	0.000341	0	0	55.01
57.00	05700	CT SCAN	3,567	31,837,395	0.000112	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,318	13,291,629	0.001905	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,687	2,744,799	0.007172	0	0	59.00
60.00	06000	LABORATORY	135,001	45,678,919	0.002955	493,025	1,457	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103	776,767	0.000133	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	7	2,309,894	0.000003	2,324	0	64.00
66.00	06600	PHYSICAL THERAPY	121,343	6,283,193	0.019312	45,742	883	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,413	1,476,424	0.001634	9,560	16	67.00
67.01	06701	AUDIOLOGY	767	855,557	0.000896	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	461	452,639	0.001018	1,375	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	18,018	10,031,735	0.001796	96,114	173	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,664	4,818,011	0.001176	65,792	77	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,425	6,083,952	0.001220	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,614	12,927,598	0.000280	616,614	173	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	56,002	0	0.000000	0	0	90.01
90.02	09002	CLINIC	2,643	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	2	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	12	120,547	0.000100	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	30	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	8	632,649	0.000013	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	493	657,576	0.000750	0	0	90.13
90.14	09014	WOUND CARE	46,207	2,494,210	0.018526	0	0	90.14
91.00	09100	EMERGENCY	322,649	28,839,483	0.011188	7,326	82	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,318,233	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,271,244	244,207,187		1,415,841	3,858	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	40,267,212	0.000000	0.000000	565	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,543,930	0.000000	0.000000	77,404	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0	7,764,835	0.000000	0.000000	0	55.01
57.00	05700	CT SCAN	0	31,837,395	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,291,629	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,744,799	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	45,678,919	0.000000	0.000000	493,025	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	776,767	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,309,894	0.000000	0.000000	2,324	64.00
66.00	06600	PHYSICAL THERAPY	0	6,283,193	0.000000	0.000000	45,742	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,476,424	0.000000	0.000000	9,560	67.00
67.01	06701	AUDIOLOGY	0	855,557	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	452,639	0.000000	0.000000	1,375	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0	10,031,735	0.000000	0.000000	96,114	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,818,011	0.000000	0.000000	65,792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,083,952	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,927,598	0.000000	0.000000	616,614	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0	120,547	0.000000	0.000000	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	632,649	0.000000	0.000000	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0.000000	0	90.12
90.13	09013	ALLERGY CLINIC	0	657,576	0.000000	0.000000	0	90.13
90.14	09014	WOUND CARE	0	2,494,210	0.000000	0.000000	0	90.14
91.00	09100	EMERGENCY	0	28,839,483	0.000000	0.000000	7,326	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,318,233	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	244,207,187			1,415,841	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	0	0		55.01
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	06701	AUDIOLOGY	0	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	460	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0	0		90.13
90.14	09014	WOUND CARE	0	0	0		90.14
91.00	09100	EMERGENCY	0	460	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	920	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.117539	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261826	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.078206	0	0	0	0	55.01
57.00	05700	CT SCAN	0.028438	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091729	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245105	0	0	0	0	59.00
60.00	06000	LABORATORY	0.150722	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.059573	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001218	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.380668	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384859	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.293896	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.331551	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.149652	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.524576	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.546172	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100958	460	0	1,213	46	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006786	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001728	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.297233	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.317221	0	0	0	0	90.14
91.00	09100	EMERGENCY	0.173947	460	0	0	80	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.574551	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.408849		0			95.00
200.00		Subtotal (see instructions)		920	0	1,213	126	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		920	0	1,213	126	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	122		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	0		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	122		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	122		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Component CCN: 155832 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Component CCN: 155832 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	40,267,212	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,543,930	0.000000	0.000000	25,019	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0	7,764,835	0.000000	0.000000	0	55.01
57.00	05700	CT SCAN	0	31,837,395	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,291,629	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,744,799	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	45,678,919	0.000000	0.000000	112,458	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	776,767	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,309,894	0.000000	0.000000	16,989	64.00
66.00	06600	PHYSICAL THERAPY	0	6,283,193	0.000000	0.000000	455,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,476,424	0.000000	0.000000	494,572	67.00
67.01	06701	AUDIOLOGY	0	855,557	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	452,639	0.000000	0.000000	32,778	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0	10,031,735	0.000000	0.000000	124,431	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,818,011	0.000000	0.000000	100,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,083,952	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,927,598	0.000000	0.000000	397,624	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0	120,547	0.000000	0.000000	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	632,649	0.000000	0.000000	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0.000000	0.000000	0	90.12
90.13	09013	ALLERGY CLINIC	0	657,576	0.000000	0.000000	0	90.13
90.14	09014	WOUND CARE	0	2,494,210	0.000000	0.000000	0	90.14
91.00	09100	EMERGENCY	0	28,839,483	0.000000	0.000000	420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,318,233	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	244,207,187			1,759,733	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Component CCN: 155832 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	0	0		55.01
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	06701	AUDIOLOGY	0	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0	0		90.13
90.14	09014	WOUND CARE	0	0	0		90.14
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150104	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,867	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,867	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)	4,758	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)	2,174	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,046,416	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,046,416	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,046,416	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)	1,201.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,611,039	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,611,039	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 2:21 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,255,315	1,563	1,442.94	664	958,112	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,132,435	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,701,586	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)	162,053	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	82,863	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	244,916	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,456,670	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)	1,109	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,201.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,331,942	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	331,478	7,046,416	0.047042	1,331,942	62,657	90.00
91.00	Nursing School cost	0	7,046,416	0.000000	1,331,942	0	91.00
92.00	Allied health cost	0	7,046,416	0.000000	1,331,942	0	92.00
93.00	All other Medical Education	0	7,046,416	0.000000	1,331,942	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,827	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,827	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,827	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)	2,358	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)	2,686,338	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)	2,686,338	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)	2,686,338	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)	950.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,240,666	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,240,666	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Subprovider - IPF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	228,616	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,469,282	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)	94,839	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,858	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	98,697	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,370,585	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	113,713	2,686,338	0.042330	0	0	90.00
91.00	Nursing School cost	0	2,686,338	0.000000	0	0	91.00
92.00	Allied health cost	0	2,686,338	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,686,338	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150104 Component CCN: 155832	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,738	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,738	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,738	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)	1,350	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)	1,350	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)	1,364,479	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)	1,364,479	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)	1,364,479	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1

Component CCN: 155832 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Skilled Nursing Facility | 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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	1,364,479	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	785.09	71.00
72.00	Program routine service cost (line 9 x line 71)	1,059,872	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,059,872	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,059,872	83.00
84.00	Program inpatient ancillary services (see instructions)	509,455	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,569,327	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150104 Component CCN: 155832	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,867	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,867	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)	4,758	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)	245	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)	1,030	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,046,416	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,046,416	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,046,416	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)	1,201.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	294,252	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)	294,252	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	6,849	1,030	6.65	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,255,315	1,563	1,442.94	0	0	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)	141,941	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	436,193	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,109	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,201.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,331,942	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	331,478	7,046,416	0.047042	1,331,942	62,657	90.00
91.00	Nursing School cost	0	7,046,416	0.000000	1,331,942	0	91.00
92.00	Allied health cost	0	7,046,416	0.000000	1,331,942	0	92.00
93.00	All other Medical Education	0	7,046,416	0.000000	1,331,942	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,143,507		30.00
31.00	03100	INTENSIVE CARE UNIT		1,359,578		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.117539	4,371,437	513,814	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261826	1,123,078	294,051	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.078206	63,755	4,986	55.01
57.00	05700	CT SCAN	0.028438	1,542,321	43,861	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091729	65,043	5,966	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245105	466,561	114,356	59.00
60.00	06000	LABORATORY	0.150722	4,152,920	625,936	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.059573	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001218	392,245	478	64.00
66.00	06600	PHYSICAL THERAPY	0.380668	362,638	138,045	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384859	175,190	67,423	67.00
67.01	06701	AUDIOLOGY	0.293896	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.331551	33,062	10,962	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.149652	2,236,147	334,644	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.524576	908,038	476,335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.546172	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100958	2,593,362	261,821	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006786	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001728	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.297233	0	0	90.13
90.14	09014	WOUND CARE	0.317221	271	86	90.14
91.00	09100	EMERGENCY	0.173947	1,377,842	239,671	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.574551	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		19,863,910	3,132,435	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		19,863,910		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,463,315		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.117539	565	66	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261826	77,404	20,266	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.078206	0	0	55.01
57.00	05700	CT SCAN	0.028438	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091729	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245105	0	0	59.00
60.00	06000	LABORATORY	0.150722	493,025	74,310	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.059573	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001218	2,324	3	64.00
66.00	06600	PHYSICAL THERAPY	0.380668	45,742	17,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384859	9,560	3,679	67.00
67.01	06701	AUDIOLOGY	0.293896	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.331551	1,375	456	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.149652	96,114	14,384	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.524576	65,792	34,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.546172	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100958	616,614	62,252	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006786	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001728	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.297233	0	0	90.13
90.14	09014	WOUND CARE	0.317221	0	0	90.14
91.00	09100	EMERGENCY	0.173947	7,326	1,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.574551	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,415,841	228,616	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,415,841		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3

Component CCN: 155832 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.117539	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261826	25,019	6,551	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.078206	0	0	55.01
57.00	05700	CT SCAN	0.028438	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091729	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245105	0	0	59.00
60.00	06000	LABORATORY	0.150722	112,458	16,950	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.059573	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001218	16,989	21	64.00
66.00	06600	PHYSICAL THERAPY	0.380668	455,041	173,220	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384859	494,572	190,340	67.00
67.01	06701	AUDIOLOGY	0.293896	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.331551	32,778	10,868	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.149652	124,431	18,621	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.524576	100,401	52,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.546172	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100958	397,624	40,143	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006786	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001728	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.297233	0	0	90.13
90.14	09014	WOUND CARE	0.317221	0	0	90.14
91.00	09100	EMERGENCY	0.173947	420	73	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.574551	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,759,733	509,455	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,759,733		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/24/2016 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		659,328		30.00
31.00	03100	INTENSIVE CARE UNIT		51,745		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		154,847		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.117539	151,212	17,773	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.261826	20,958	5,487	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.078206	8,597	672	55.01
57.00	05700	CT SCAN	0.028438	61,556	1,751	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091729	11,008	1,010	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.245105	27,772	6,807	59.00
60.00	06000	LABORATORY	0.150722	174,229	26,260	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.059573	10,017	597	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001218	35,716	44	64.00
66.00	06600	PHYSICAL THERAPY	0.380668	6,281	2,391	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384859	2,989	1,150	67.00
67.01	06701	AUDIOLOGY	0.293896	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.331551	527	175	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.149652	56,314	8,428	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.524576	79,844	41,884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.546172	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100958	152,616	15,408	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.006786	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001728	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.297233	0	0	90.13
90.14	09014	WOUND CARE	0.317221	0	0	90.14
91.00	09100	EMERGENCY	0.173947	69,585	12,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.574551	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		869,221	141,941	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		869,221		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A | Date/Time Prepared: 5/24/2016 2:21 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)		4,275,197		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,308,462		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)		22,111		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		64.96		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)		3.71		30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.94		31.00
32.00	Sum of lines 30 and 31		31.65		32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00		33.00
34.00	Disproportionate share adjustment (see instructions)		167,510		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000056846	0.000055964	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		434,737	358,513	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		325,159	90,118	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		415,277		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		6,188,557		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)		6,188,557		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		447,898		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,636,455		59.00
60.00	Primary payer payments		8,298		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,628,157		61.00
62.00	Deductibles billed to program beneficiaries		849,020		62.00
63.00	Coinsurance billed to program beneficiaries		3,150		63.00
64.00	Allowable bad debts (see instructions)		101,400		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		65,910		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		70,836		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,841,897		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)		18,038		70.93
70.94	HRR adjustment amount (see instructions)		-5,750		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2015	500,081		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)	2016	181,594		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		52,390		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,483,470		71.00
71.01	Sequestration adjustment (see instructions)		129,669		71.01
72.00	Interim payments		6,293,810		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)		59,991		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		310,232		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,275,197	0	4,275,197	0	4,275,197	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,308,462	0	0	1,308,462	1,308,462	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	22,111	0	9,574	12,537	22,111	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	167,510	0	128,256	39,254	167,510	11.00
11.01	Uncompensated care payments	36.00	415,277	0	325,159	90,118	415,277	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,188,557	0	4,738,186	1,450,371	6,188,557	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,188,557	0	4,738,186	1,450,371	6,188,557	15.00
16.00	Payment for inpatient program capital	50.00	447,898	704	306	446,888	447,898	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			704	4,738,492	1,897,259	6,636,455	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	446,888	0	0	446,888	446,888	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,010	704	306	0	1,010	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	447,898	704	306	446,888	447,898	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.105536	0.095714		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			500,081		500,081	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				181,594	181,594	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,275,197	4,275,197		4,275,197	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,308,462		1,308,462	1,308,462	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	22,111	9,574	12,537	22,111	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	167,510	128,256	39,254	167,510	11.00
11.01	Uncompensated care payments	36.00	415,277	325,159	90,118	415,277	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,188,557	4,738,186	1,450,371	6,188,557	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,188,557	4,738,186	1,450,371	6,188,557	15.00
16.00	Payment for inpatient program capital	50.00	447,898	755	447,143	447,898	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,738,941	1,897,514	6,636,455	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	446,888	0	446,888	446,888	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,010	755	255	1,010	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	447,898	755	447,143	447,898	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	500,081	500,081		500,081	28.00
29.00	Low volume adjustment on or after October 1	70.97	181,594		181,594	181,594	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	18,038	0	18,038	18,038	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-5,750	0	-5,750	-5,750	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		52,390	0	52,390	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150104	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,445	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,399,568	2.00
3.00	PPS payments	7,214,394	3.00
4.00	Outlier payment (see instructions)	2,249	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)	1,445	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	14,313	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	14,313	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	14,313	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	12,868	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)	1,445	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)	7,216,643	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,595,171	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	5,622,917	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,622,917	30.00
31.00	Primary payer payments	493	31.00
32.00	Subtotal (line 30 minus line 31)	5,622,424	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)	105,789	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	68,763	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	94,679	36.00
37.00	Subtotal (see instructions)	5,691,187	37.00
38.00	MSP-LCC reconciliation amount from PS&R	211	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,690,976	40.00
40.01	Sequestration adjustment (see instructions)	113,820	40.01
41.00	Interim payments	5,507,092	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	70,064	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	122	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	126	2.00
3.00	PPS payments	193	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	122	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,213	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)	1,213	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,213	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,091	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)	122	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)	193	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	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)	315	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)	315	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	315	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	315	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)	315	40.00
40.01	Sequestration adjustment (see instructions)	6	40.01
41.00	Interim payments	427	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-118	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: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2016 2:21 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		6,293,810		5,507,092	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)		6,293,810		5,507,092	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		59,991		70,064	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,353,801		5,577,156	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2016 2:21 pm

Component CCN: 15S104 | Title XVIII | Subprovider - IPF | 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		2,110,155		427	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)		2,110,155		427	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		3		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		118	6.02
7.00	Total Medicare program liability (see instructions)		2,110,158		309	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150104 | Component CCN: 155832 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2016 2:21 pm

Title XVIII | Skilled Nursing Facility | 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		546,896		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		546,896		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		546,896		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150104	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/24/2016 2:21 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	2,266	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,838	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	604	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	6,321	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	270,648,601	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,884,874	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)	305,940	8.00
9.00	Sequestration adjustment amount (see instructions)	6,119	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	299,821	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	311,761	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)	-11,940	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150104	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part II Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,201,895	1.00
2.00	Net IPF PPS Outlier Payments	107,347	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	7.745205	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,309,242	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,309,242	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,309,242	18.00
19.00	Deductibles	154,760	19.00
20.00	Subtotal (line 18 minus line 19)	2,154,482	20.00
21.00	Coinsurance	1,260	21.00
22.00	Subtotal (line 20 minus line 21)	2,153,222	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,153,222	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,153,222	31.00
31.01	Sequestration adjustment (see instructions)	43,064	31.01
32.00	Interim payments	2,110,155	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	3	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	107,347	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150104 Component CCN: 155832	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VI Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	616,017	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	616,017	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	57,960	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	558,057	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	558,057	15.00
15.01	Sequestration adjustment (see instructions)	11,161	15.01
16.00	Interim payments	546,896	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-3 Part VII Date/Time Prepared: 5/24/2016 2:21 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	436,193		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	436,193	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	436,193	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	865,920		8.00
9.00	Ancillary service charges	869,221	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,735,141	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,735,141	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,298,948	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	436,193	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	436,193	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	436,193	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	436,193	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	436,193	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	436,193	0	40.00
41.00	Interim payments	667,218	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-231,025	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/24/2016 2:21 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	27,118,394	0	0	0	1.00
2.00	Temporary investments	15,753,613	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,325,093	0	0	0	4.00
5.00	Other receivable	1,134,195	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,780,444	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,784,000	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)	64,895,739	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	15,081,204	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	142,942	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	132,523,982	0	0	0	23.00
24.00	Accumulated depreciation	-60,484,429	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)	87,263,699	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	10,848,918	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,848,918	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	163,008,356	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,789,456	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,135,604	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,475,972	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,401,032	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	56,614,446	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	56,614,446	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	72,015,478	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	90,992,878				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)	90,992,878	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	163,008,356	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/24/2016 2:21 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		79,605,719		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,387,159				2.00
3.00	Total (sum of line 1 and line 2)		90,992,878		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		90,992,878		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		90,992,878		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2016 2:21 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,869,810		15,869,810	1.00
2.00	SUBPROVIDER - IPF	2,995,813		2,995,813	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	847,004		847,004	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)	19,712,627		19,712,627	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,409,252		3,409,252	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)	3,409,252		3,409,252	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	23,121,879		23,121,879	17.00
18.00	Ancillary services	40,246,192	177,432,820	217,679,012	18.00
19.00	Outpatient services	3,308,845	29,878,021	33,186,866	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	2,570	6,269,013	6,271,583	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	EH&S, DIETARY, PHYSICIAN PRIVATE OFF	1,819	37,695,730	37,697,549	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	66,681,305	251,275,584	317,956,889	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		105,933,337		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)		105,933,337		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150104 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-3 | Date/Time Prepared: 5/24/2016 2:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	317,956,889	1.00
2.00	Less contractual allowances and discounts on patients' accounts	207,974,779	2.00
3.00	Net patient revenues (line 1 minus line 2)	109,982,110	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	105,933,337	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,048,773	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPER/NON OPER REV/TRANSERS	7,345,893	24.00
25.00	Total other income (sum of lines 6-24)	7,345,893	25.00
26.00	Total (line 5 plus line 25)	11,394,666	26.00
27.00	ADDITIONAL BAD DEBT	7,507	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	7,507	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,387,159	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150104	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/24/2016 2:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	446,888	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,010	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)	18.01	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)	447,898	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