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: 140058	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/15/2016 3:55 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/15/2016 Time: 3:55 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 PASSAVANT AREA HOSPITAL (140058) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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	-145,868	100,190	750,789	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	54		0	7.00
200.00	Total	0	-145,868	100,244	750,789	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/15/2016 10:39 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1600 WEST WALNUT	PO Box:			1.00
2.00	City: JACKSONVILLE	State: IL	Zip Code: 62650-1185	County: MORGAN	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	PASSAVANT AREA HOSPITAL	140058	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	PASSAVANT AREA HOSPITAL	145951	99914		10/31/1997	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	1	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.	2,194	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/15/2016 10:39 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	10/01/2014	09/30/2015	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/15/2016 10:39 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/15/2016 10:39 am

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	132,736	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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/15/2016 10:39 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	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: MEMORIAL HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	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)	0.50	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)	06/01/2015	08/29/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140058	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/15/2016 10:39 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/15/2016 10:39 am

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	01/15/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/15/2016 10:39 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/15/2016 10:39 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	01/15/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR		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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/15/2016 10:39 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	84	30,660	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)		84	30,660	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9	3,285	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)		93	33,945	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	15	5,475		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)		108				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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/15/2016 10:39 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,763	1,515	8,426			1.00
2.00	HMO and other (see instructions)	587	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,763	1,515	8,426			7.00
8.00	INTENSIVE CARE UNIT	736	167	1,141			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		512	792			13.00
14.00	Total (see instructions)	5,499	2,194	10,359	0.00	652.98	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,087	0	3,765	0.00	16.86	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	669.84	27.00
28.00	Observation Bed Days		175	741			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			267			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	140			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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/15/2016 10:39 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,462	566	3,023	1.00
2.00	HMO and other (see instructions)			166	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,462	566	3,023	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/15/2016 10:39 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	33,742,016	0	33,742,016	1,397,090.93	24.15	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		8,250	0	8,250	59.50	138.66	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		195,748	0	195,748	1,411.76	138.66	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	793,514	0	793,514	35,163.65	22.57	9.00
10.00	Excluded area salaries (see instructions)		53,615	0	53,615	2,309.29	23.22	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		125,453	0	125,453	3,270.99	38.35	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		121,410	0	121,410	996.75	121.81	13.00
14.00	Home office salaries & wage-related costs		731,138	0	731,138	2,080.00	351.51	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)		12,097,403	0	12,097,403			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		339,435	0	339,435			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		1,392	0	1,392			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		33,040	0	33,040			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	330,251	0	330,251	12,933.21	25.54	26.00
27.00	Administrative & General	5.00	6,207,732	0	6,207,732	230,207.02	26.97	27.00
28.00	Administrative & General under contract (see inst.)		182,126	0	182,126	3,041.78	59.87	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,055,011	0	1,055,011	39,028.12	27.03	30.00
31.00	Laundry & Linen Service	8.00	222,330	0	222,330	17,036.67	13.05	31.00
32.00	Housekeeping	9.00	896,404	0	896,404	74,385.63	12.05	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,103,764	-796,586	307,178	21,880.17	14.04	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	796,586	796,586	56,740.65	14.04	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	598,304	0	598,304	18,253.23	32.78	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	736,513	0	736,513	21,110.77	34.89	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/15/2016 10:39 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	624,874	0	624,874	31,744.76	19.68	41.00
42.00	Social Service	17.00	124,510	0	124,510	4,259.78	29.23	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 2/15/2016 10:39 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		33,728,394	0	33,728,394	1,398,720.95	24.11	1.00
2.00	Excluded area salaries (see instructions)		847,129	0	847,129	37,472.94	22.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,881,265	0	32,881,265	1,361,248.01	24.16	3.00
4.00	Subtotal other wages & related costs (see inst.)		978,001	0	978,001	6,347.74	154.07	4.00
5.00	Subtotal wage-related costs (see inst.)		12,098,795	0	12,098,795	0.00	36.80	5.00
6.00	Total (sum of lines 3 thru 5)		45,958,061	0	45,958,061	1,367,595.75	33.61	6.00
7.00	Total overhead cost (see instructions)		12,081,819	0	12,081,819	530,621.79	22.77	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 2/15/2016 10:39 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,582,611	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)	7,513,473	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	23,519	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)	159,505	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	645,727	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	2,516,139	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-12,743	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	43,039	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,471,270	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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 2/15/2016 10:39 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	307,579	0	1.00
2.00	Hospital	307,579	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/15/2016 10:39 am

		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.	N		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.	N		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	13	0	13	4.00
5.00		RVX	13	0	13	5.00
6.00		RVL	13	0	13	6.00
7.00		RHX	22	0	22	7.00
8.00		RHL	78	0	78	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	10	0	10	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	68	0	68	12.00
13.00		RUB	23	0	23	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	14	0	14	15.00
16.00		RVB	94	0	94	16.00
17.00		RVA	1,062	0	1,062	17.00
18.00		RHC	109	0	109	18.00
19.00		RHB	96	0	96	19.00
20.00		RHA	960	0	960	20.00
21.00		RMC	63	0	63	21.00
22.00		RMB	16	0	16	22.00
23.00		RMA	199	0	199	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	3	0	3	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	6	0	6	30.00
31.00		HD2	14	0	14	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	2	0	2	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	1	0	1	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	8	0	8	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	13	0	13	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	11	0	11	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	35	0	35	46.00
47.00		CD2	26	0	26	47.00
48.00		CD1	17	0	17	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	5	0	5	50.00
51.00		CB2	5	0	5	51.00
52.00		CB1	17	0	17	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	42	0	42	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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/15/2016 10:39 am

		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	24	0	24	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	5	0	5	199.00
200.00	TOTAL		3,087	0	3,087	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).	99914	99914	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	793,514	14.16	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		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)	5,605,330			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/15/2016 10:39 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.252538	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,734,079	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	6,253,144	5.00
6.00	Medicaid charges	52,495,770	6.00
7.00	Medicaid cost (line 1 times line 6)	13,257,177	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,269,954	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	230,117	9.00
10.00	Stand-alone SCHIP charges	966,143	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	243,988	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	13,871	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,283,825	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	3,986,754	0	3,986,754	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,006,807	0	1,006,807	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)	1,006,807	0	1,006,807	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,392,870	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	638,905	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,753,965	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	695,481	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,702,288	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,986,113	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,519,047	1,519,047	992,280	2,511,327	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,533,029	1,533,029	92,147	1,625,176	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	330,251	12,683,150	13,013,401	0	13,013,401	4.00
5.01	00540	NONPATIENT TELEPHONES	0	51,450	51,450	0	51,450	5.01
5.02	00550	DATA PROCESSING	967,887	1,569,279	2,537,166	0	2,537,166	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	316,190	150,131	466,321	0	466,321	5.03
5.04	00570	ADMITTING	679,138	18,466	697,604	0	697,604	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	740,361	551,318	1,291,679	0	1,291,679	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	3,504,156	5,787,484	9,291,640	0	9,291,640	5.06
7.00	00700	OPERATION OF PLANT	1,055,011	2,089,250	3,144,261	-144,342	2,999,919	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	222,330	126,023	348,353	0	348,353	8.00
9.00	00900	HOUSEKEEPING	896,404	168,114	1,064,518	0	1,064,518	9.00
10.00	01000	DIETARY	1,103,764	1,020,960	2,124,724	-1,533,413	591,311	10.00
11.00	01100	CAFETERIA	0	0	0	1,533,413	1,533,413	11.00
13.00	01300	NURSING ADMINISTRATION	598,304	38,066	636,370	0	636,370	13.00
15.00	01500	PHARMACY	736,513	3,113,701	3,850,214	-2,631,434	1,218,780	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	624,874	86,136	711,010	0	711,010	16.00
17.00	01700	SOCIAL SERVICE	124,510	542	125,052	0	125,052	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,860,940	780,625	4,641,565	-1,285	4,640,280	30.00
31.00	03100	INTENSIVE CARE UNIT	1,029,035	60,405	1,089,440	-173	1,089,267	31.00
43.00	04300	NURSERY	341,438	45,297	386,735	0	386,735	43.00
44.00	04400	SKILLED NURSING FACILITY	793,514	39,352	832,866	-15	832,851	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,940,590	4,590,329	8,530,919	-1,848,430	6,682,489	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	85,359	11,324	96,683	0	96,683	52.00
53.00	05300	ANESTHESIOLOGY	46,553	275,677	322,230	0	322,230	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,283,054	1,190,000	3,473,054	0	3,473,054	54.00
60.00	06000	LABORATORY	1,882,130	1,982,533	3,864,663	0	3,864,663	60.00
65.00	06500	RESPIRATORY THERAPY	716,272	298,590	1,014,862	0	1,014,862	65.00
66.00	06600	PHYSICAL THERAPY	2,244,752	289,706	2,534,458	0	2,534,458	66.00
68.00	06800	SPEECH PATHOLOGY	184,271	6,225	190,496	0	190,496	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,316	543	5,859	0	5,859	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,968	347,081	466,049	-20,443	445,606	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,868,873	1,868,873	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,632,907	2,632,907	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	138,222	32,082	170,304	0	170,304	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	92,462	29,897	122,359	0	122,359	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	458,415	151,739	610,154	0	610,154	90.00
91.00	09100	EMERGENCY	3,567,417	2,095,671	5,663,088	0	5,663,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,084,427	1,084,427	-1,084,427	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,688,401	43,817,649	77,506,050	-144,342	77,361,708	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	53,615	3,771	57,386	144,342	201,728	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	33,742,016	43,821,420	77,563,436	0	77,563,436	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,498,570	4,009,897		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,788,390	3,413,566		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,204,477	9,808,924		4.00
5.01	00540	NONPATIENT TELEPHONES	-7,816	43,634		5.01
5.02	00550	DATA PROCESSING	0	2,537,166		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	466,321		5.03
5.04	00570	ADMITTING	0	697,604		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,291,679		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-1,401,513	7,890,127		5.06
7.00	00700	OPERATION OF PLANT	-16,469	2,983,450		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	348,353		8.00
9.00	00900	HOUSEKEEPING	0	1,064,518		9.00
10.00	01000	DIETARY	-59,725	531,586		10.00
11.00	01100	CAFETERIA	-470,264	1,063,149		11.00
13.00	01300	NURSING ADMINISTRATION	0	636,370		13.00
15.00	01500	PHARMACY	-300	1,218,480		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-32,158	678,852		16.00
17.00	01700	SOCIAL SERVICE	0	125,052		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-487,925	4,152,355		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,089,267		31.00
43.00	04300	NURSERY	0	386,735		43.00
44.00	04400	SKILLED NURSING FACILITY	0	832,851		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-18,492	6,663,997		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	96,683		52.00
53.00	05300	ANESTHESIOLOGY	0	322,230		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,473,054		54.00
60.00	06000	LABORATORY	-75,000	3,789,663		60.00
65.00	06500	RESPIRATORY THERAPY	-1,222	1,013,640		65.00
66.00	06600	PHYSICAL THERAPY	-136,238	2,398,220		66.00
68.00	06800	SPEECH PATHOLOGY	0	190,496		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,859		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	445,606		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,868,873		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,632,907		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	170,304		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-944	121,415		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-9,889	600,265		90.00
91.00	09100	EMERGENCY	-1,389,342	4,273,746		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,024,814	73,336,894		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	201,728		192.00
192.01	19201	RENTED SPACE	0	0		192.01
194.00	07950	FUND DEVELOPMENT	0	0		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,024,814	73,538,622		200.00

RECLASSIFICATIONS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/15/2016 10:39 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	796,586	736,827	1.00
	0		796,586	736,827	
	B - RECLASS SPOILED DRUGS EXPENSE				
1.00	PHARMACY	15.00	0	1,473	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	1,473	
	C - RECLASS CHARGEABLE DRUG COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,632,907	1.00
	0		0	2,632,907	
	D - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	992,280	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	92,147	2.00
	0		0	1,084,427	
	G - RECLASS REAL ESTATE TAXES				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	144,342	1.00
	0		0	144,342	
	H - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,868,873	1.00
2.00		0.00	0	0	2.00
	0		0	1,868,873	
500.00	Grand Total: Increases		796,586	6,468,849	500.00

RECLASSIFICATIONS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/15/2016 10:39 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	796,586	736,827	0		1.00
	0		796,586	736,827			
	B - RECLASS SPOILED DRUGS EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	1,285	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	173	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	15	0		3.00
	0		0	1,473			
	C - RECLASS CHARGEABLE DRUG COSTS						
1.00	PHARMACY	15.00	0	2,632,907	0		1.00
	0		0	2,632,907			
	D - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,084,427	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,084,427			
	G - RECLASS REAL ESTATE TAXES						
1.00	OPERATION OF PLANT	7.00	0	144,342	0		1.00
	0		0	144,342			
	H - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	1,848,430	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	20,443	0		2.00
	0		0	1,868,873			
500.00	Grand Total: Decreases		796,586	6,468,849			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/15/2016 10:39 am

		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	242,737	0	0	0	0	1.00
2.00	Land Improvements	3,227,192	77,462	0	77,462	0	2.00
3.00	Buildings and Fixtures	39,999,025	737,750	0	737,750	0	3.00
4.00	Building Improvements	0	5,121,823	0	5,121,823	0	4.00
5.00	Fixed Equipment	45,175,224	775,959	0	775,959	13,737	5.00
6.00	Movable Equipment	40,094,970	730,297	0	730,297	2,468,032	6.00
7.00	HIT designated Assets	1,757,341	709,539	0	709,539	0	7.00
8.00	Subtotal (sum of lines 1-7)	130,496,489	8,152,830	0	8,152,830	2,481,769	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	130,496,489	8,152,830	0	8,152,830	2,481,769	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	242,737	0	1.00
2.00	Land Improvements	3,304,654	0	2.00
3.00	Buildings and Fixtures	40,736,775	0	3.00
4.00	Building Improvements	5,121,823	0	4.00
5.00	Fixed Equipment	45,937,446	0	5.00
6.00	Movable Equipment	38,357,235	0	6.00
7.00	HIT designated Assets	2,466,880	0	7.00
8.00	Subtotal (sum of lines 1-7)	136,167,550	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	136,167,550	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/15/2016 10:39 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,189,378	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,533,029	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,722,407	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	329,669	1,519,047		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,533,029		2.00
3.00	Total (sum of lines 1-2)	329,669	3,052,076		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/15/2016 10:39 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	88,644,178	0	88,644,178	0.684823	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	41,852,311	1,055,527	40,796,784	0.315177	0	2.00
3.00	Total (sum of lines 1-2)	130,496,489	1,055,527	129,440,962	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	CAP REL COSTS-BLDG & FIXT	0	0	0	2,750,914	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,327,266	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,078,180	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	929,314	0	0	329,669	4,009,897	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	86,300	0	0	0	3,413,566	2.00
3.00	Total (sum of lines 1-2)	1,015,614	0	0	329,669	7,423,463	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/15/2016 10:39 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-62,966	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-5,847	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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)	A	-7,816	NONPATIENT TELEPHONES	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-16,469	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,536,382			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,976,353			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-470,264	CAFETERIA	11.00	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	B	-32,158	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-12,018	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	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HEALTH EDUCATION	B	-710	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/15/2016 10:39 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS INCOME	B	-38,474	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.01
33.02	WEE CARE	B	-754	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.02
33.03	DOORBELL DINNERS	B	-47,707	DIETARY	10.00	0	33.03
33.04	CHILDBIRTH PREP	B	-170	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.04
33.05			0		0.00	0	33.05
33.06	MISCELLANEOUS PT INCOME	B	-135,422	PHYSICAL THERAPY	66.00	0	33.06
33.07	MISCELLANEOUS ER INCOME	B	-10,153	EMERGENCY	91.00	0	33.07
33.08	MISCELLANEOUS WOC CONTRACTUAL INCOME	B	-9,889	CLINIC	90.00	0	33.08
33.09	INDUSTRIAL REHAB CABLE EXPENSE	A	-816	PHYSICAL THERAPY	66.00	0	33.09
33.10	HYPERBARICS CABLE EXPENSE	A	-944	HYPERBARIC OXYGEN THERAPY	76.98	0	33.10
33.11			0		0.00	0	33.11
33.12	INTERMEDIARY DEPRECIATION ADJUSTMENT	A	30,552	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	INTERMEDIARY DEPRECIATION ADJUSTMENT	A	-1,125	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	SELF INSURANCE	A	-2,985,593	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	PHYSICIAN RECRUITMENT	A	-83,478	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.15
33.16	PARAMEDIC SALARY EXPENSE	A	-14,657	EMERGENCY	91.00	0	33.16
33.17	PARAMEDIC EMPLOYEE BENEFIT EXPENSE	A	-4,158	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	PARAMEDIC OTHER EXPENSE	A	-541	EMERGENCY	91.00	0	33.18
33.19	PARAMEDIC CRC EXPENSE	A	-497	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20	INCOME TAX EXPENSE	A	-8,688	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.20
33.21	LOBBYING EXPENSE	A	-30,004	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.21
33.22	COMMUNITY RELATIONS SALARY EXPENSE	A	-229,948	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.22
33.23	COMMUNITY RELATIONS BENEFITS EXPENS	A	-65,236	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	COMMUNITY RELATIONS OTHER EXPENSE	A	-249,595	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.24
33.25	ALCOHOL EXPENSE	A	-1,335	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.25
33.26	TRUST ACCOUNT FEES	A	226,615	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.26
33.27	LIFE LINE EXPENSES	A	-62,054	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.27
33.28	PROVIDER TAX EXPENSE	A	-2,141,651	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.28
33.29			0		0.00	0	33.29
33.30			0		0.00	0	33.30
33.31			0		0.00	0	33.31
33.32	EDUCATION INCOME - AHA	B	-13,023	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.32
33.33	PHARMACY MISCELLANEOUS INCOME	B	-300	PHARMACY	15.00	0	33.33
33.34	EMPLOYEE SERVICES INCOME	B	-3,120	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.34
33.35			0		0.00	0	33.35
33.36	PHYSICIAN LOAN FORGIVENESS	A	-68,192	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.36
33.37			0		0.00	0	33.37
33.38	REVALUED ASSETS DEPRECIATION ADJ	A	1,461,500	CAP REL COSTS-BLDG & FIXT	1.00	9	33.38
33.39	REVALUED ASSETS DEPRECIATION ADJ	A	1,793,250	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.39
33.40	SURGERY MISC INCOME	B	-7,992	OPERATING ROOM	50.00	0	33.40
33.41	EXECUTIVE OFFICE EXPENSE	A	-3,448	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.41
33.42	COMMUNITY BENEFIT SALARY EXPENSE	A	-57,344	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.42
33.43	COMMUNITY BENEFIT BENEFITS EXPENS	A	-16,268	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.43
33.44	COMMUNITY BENEFIT OTHER EXPENSE	A	-75,878	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44

ADJUSTMENTS TO EXPENSES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/15/2016 10:39 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,024,814				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/15/2016 10:39 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAP BLDG HO	70,609	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAP MME HO MME CAP	1,484	0	2.00
3.00	5.06	OTHER ADMINISTRATIVE AND GEN	HO INTEREST	17,326	0	3.00
4.00	5.06	OTHER ADMINISTRATIVE AND GEN	A&G HO MANAGEMENT	2,377,359	490,425	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,466,778	490,425	5.00

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

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

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

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

6.00	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	C		0.00	PPA	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140058	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/15/2016 10:39 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	70,609	9		1.00
2.00	1,484	9		2.00
3.00	17,326	0		3.00
4.00	1,886,934	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	1,976,353			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	PHYSICIAN ORG		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/15/2016 10:39 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	624,864	549,067	75,797	159,800	353	1.00
2.00	30.00	ADULTS & PEDIATRICS	487,925	487,925	0	0	0	2.00
3.00	50.00	OPERATING ROOM	10,500	10,500	0	0	0	3.00
4.00	60.00	LABORATORY	75,000	75,000	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	1,913	0	1,913	159,800	9	5.00
6.00	91.00	EMERGENCY	1,415,941	1,363,991	51,950	159,800	695	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			2,616,143	2,486,483	129,660		1,057	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	27,120	1,356	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	691	35	0	0	0	5.00
6.00	91.00	EMERGENCY	53,395	2,670	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			81,206	4,061	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	27,120	48,677	597,744		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	487,925		2.00
3.00	50.00	OPERATING ROOM	0	0	0	10,500		3.00
4.00	60.00	LABORATORY	0	0	0	75,000		4.00
5.00	65.00	RESPIRATORY THERAPY	0	691	1,222	1,222		5.00
6.00	91.00	EMERGENCY	0	53,395	0	1,363,991		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	81,206	49,899	2,536,382		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,009,897	4,009,897				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,413,566		3,413,566			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,808,924	93,035	52,178	9,954,137		4.00
5.01	00540	NONPATIENT TELEPHONES	43,634	12,509	0	0	56,143	5.01
5.02	00550	DATA PROCESSING	2,537,166	44,786	515,964	290,482	2,460	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	466,321	108,795	0	94,895	883	5.03
5.04	00570	ADMITTING	697,604	15,413	770	203,823	1,514	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,291,679	30,069	0	222,197	1,388	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	7,890,127	311,322	66,652	982,655	6,816	5.06
7.00	00700	OPERATION OF PLANT	2,983,450	505,662	64,413	316,630	2,649	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	348,353	84,187	11,838	66,726	252	8.00
9.00	00900	HOUSEKEEPING	1,064,518	161,703	3,775	269,029	252	9.00
10.00	01000	DIETARY	531,586	94,850	30,180	92,190	946	10.00
11.00	01100	CAFETERIA	1,063,149	61,786	0	239,071	0	11.00
13.00	01300	NURSING ADMINISTRATION	636,370	16,577	3,212	179,563	1,009	13.00
15.00	01500	PHARMACY	1,218,480	39,598	6,405	221,042	883	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	678,852	54,436	0	187,537	1,262	16.00
17.00	01700	SOCIAL SERVICE	125,052	0	0	37,368	252	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,152,355	452,924	106,848	1,158,745	4,100	30.00
31.00	03100	INTENSIVE CARE UNIT	1,089,267	81,706	31,040	308,834	694	31.00
43.00	04300	NURSERY	386,735	11,752	0	102,472	442	43.00
44.00	04400	SKILLED NURSING FACILITY	832,851	102,171	10,640	238,149	757	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,663,997	269,924	779,498	1,182,661	5,867	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	96,683	24,125	0	25,618	126	52.00
53.00	05300	ANESTHESIOLOGY	322,230	15,715	80,784	13,971	2,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,473,054	198,261	1,071,226	685,190	2,460	54.00
60.00	06000	LABORATORY	3,789,663	127,384	93,239	564,865	2,397	60.00
65.00	06500	RESPIRATORY THERAPY	1,013,640	71,315	56,947	214,968	1,135	65.00
66.00	06600	PHYSICAL THERAPY	2,398,220	142,464	17,194	673,695	2,649	66.00
68.00	06800	SPEECH PATHOLOGY	190,496	4,734	664	55,303	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,859	3,464	3,617	1,595	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	445,606	78,832	71,806	35,705	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,868,873	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,632,907	3,706	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	170,304	44,892	5,387	41,483	252	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	121,415	19,239	11,250	27,750	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	600,265	39,855	12,822	137,580	1,451	90.00
91.00	09100	EMERGENCY	4,273,746	312,048	184,348	1,066,254	5,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	73,336,894	3,639,239	3,292,697	9,938,046	50,908	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,481	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	201,728	1,906	120,869	16,091	1,135	192.00
192.01	19201	RENTED SPACE	0	349,271	0	0	4,100	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	73,538,622	4,009,897	3,413,566	9,954,137	56,143	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,390,858					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	46,423	717,317				5.03
5.04	00570	ADMITTING	46,423	10,739	976,286			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	464,513	44,196	0	2,054,042		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	232,256	96,497	0	0	9,586,325	5.06
7.00	00700	OPERATION OF PLANT	0	58,727	0	0	3,931,531	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,322	0	0	578,678	8.00
9.00	00900	HOUSEKEEPING	0	113,675	0	0	1,612,952	9.00
10.00	01000	DIETARY	232,256	22,830	0	0	1,004,838	10.00
11.00	01100	CAFETERIA	0	82,592	0	0	1,446,598	11.00
13.00	01300	NURSING ADMINISTRATION	46,423	2,992	0	0	886,146	13.00
15.00	01500	PHARMACY	92,845	9,476	0	0	1,588,729	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	464,513	0	0	0	1,386,600	16.00
17.00	01700	SOCIAL SERVICE	46,423	15,225	0	0	224,320	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	139,411	12,245	53,555	112,662	6,192,845	30.00
31.00	03100	INTENSIVE CARE UNIT	92,845	2,610	17,453	36,715	1,661,164	31.00
43.00	04300	NURSERY	0	798	4,278	8,999	515,476	43.00
44.00	04400	SKILLED NURSING FACILITY	139,411	2,927	12,893	27,123	1,366,922	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,423	52,448	179,757	378,154	9,558,729	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	199	4,515	9,498	160,764	52.00
53.00	05300	ANESTHESIOLOGY	0	2,039	21,343	44,900	503,884	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,256	19,459	263,537	554,644	6,500,087	54.00
60.00	06000	LABORATORY	371,668	44,905	115,381	242,726	5,352,228	60.00
65.00	06500	RESPIRATORY THERAPY	371,668	22,925	60,226	126,696	1,939,520	65.00
66.00	06600	PHYSICAL THERAPY	92,845	6,283	47,351	99,611	3,480,312	66.00
68.00	06800	SPEECH PATHOLOGY	0	523	2,230	4,691	258,641	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	33	364	766	15,698	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,991	17,551	36,922	689,413	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	20,509	43,144	1,932,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	69,198	145,572	2,851,383	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,328	1,463	3,077	269,186	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	518	2,875	6,047	189,094	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,427	6,632	13,951	814,983	90.00
91.00	09100	EMERGENCY	139,411	17,000	75,175	158,144	6,231,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,298,013	716,929	976,286	2,054,042	72,730,808	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	19,481	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92,845	388	0	0	434,962	192.00
192.01	19201	RENTED SPACE	0	0	0	0	353,371	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,390,858	717,317	976,286	2,054,042	73,538,622	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	9,586,325					5.06
7.00	00700	OPERATION OF PLANT	589,329	4,520,860				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	86,743	131,772	797,193			8.00
9.00	00900	HOUSEKEEPING	241,778	253,103	25,853	2,133,686		9.00
10.00	01000	DIETARY	150,623	148,462	6,141	0	1,310,064	10.00
11.00	01100	CAFETERIA	216,842	96,710	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	132,832	25,947	0	458,217	0	13.00
15.00	01500	PHARMACY	238,147	61,980	0	44,956	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	207,849	85,204	0	26,604	0	16.00
17.00	01700	SOCIAL SERVICE	33,625	0	0	4,311	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	928,295	708,927	182,555	178,960	884,813	30.00
31.00	03100	INTENSIVE CARE UNIT	249,005	127,889	20,330	44,956	70,630	31.00
43.00	04300	NURSERY	77,269	18,395	9,750	48,856	0	43.00
44.00	04400	SKILLED NURSING FACILITY	204,899	159,920	45,169	74,926	354,621	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,432,837	422,493	251,970	180,356	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,098	37,761	2,438	12,193	0	52.00
53.00	05300	ANESTHESIOLOGY	75,531	24,598	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	974,350	310,324	56,203	84,615	0	54.00
60.00	06000	LABORATORY	802,288	199,386	279	62,979	0	60.00
65.00	06500	RESPIRATORY THERAPY	290,730	111,625	3,053	58,791	0	65.00
66.00	06600	PHYSICAL THERAPY	521,692	222,989	20,396	145,911	0	66.00
68.00	06800	SPEECH PATHOLOGY	38,770	7,410	0	32,023	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,353	5,421	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,342	123,391	0	30,135	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	289,682	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	427,417	5,800	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	40,350	70,266	145	19,748	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	28,345	30,114	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	122,164	62,382	0	0	0	90.00
91.00	09100	EMERGENCY	934,050	488,426	169,098	226,666	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,465,235	3,940,695	793,380	1,735,203	1,310,064	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,920	30,493	0	44,956	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	65,200	2,983	3,813	353,527	0	192.00
192.01	19201	RENTED SPACE	52,970	546,689	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,586,325	4,520,860	797,193	2,133,686	1,310,064	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,760,150					11.00
13.00	01300	NURSING ADMINISTRATION	33,996	1,537,138				13.00
15.00	01500	PHARMACY	39,319	0	1,973,131			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	59,134	0	0	1,765,391		16.00
17.00	01700	SOCIAL SERVICE	7,926	0	0	0	270,182	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	298,972	533,185	702	96,828	161,183	30.00
31.00	03100	INTENSIVE CARE UNIT	62,942	102,979	116	31,555	21,827	31.00
43.00	04300	NURSERY	22,185	40,546	131	7,734	15,150	43.00
44.00	04400	SKILLED NURSING FACILITY	65,506	119,222	10	23,311	72,022	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	273,874	321,840	35,263	325,004	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,556	10,135	33	8,163	0	52.00
53.00	05300	ANESTHESIOLOGY	51,791	0	47,623	38,589	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,818	10,219	81,970	476,732	0	54.00
60.00	06000	LABORATORY	158,636	0	1,794	208,611	0	60.00
65.00	06500	RESPIRATORY THERAPY	58,279	590	12,894	108,889	0	65.00
66.00	06600	PHYSICAL THERAPY	131,789	0	0	85,611	0	66.00
68.00	06800	SPEECH PATHOLOGY	7,965	0	0	4,031	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	427	0	0	658	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,930	0	8,578	31,733	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	37,080	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,772,696	125,112	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,887	8,930	0	2,645	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,983	0	0	5,197	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29,567	37,615	1,852	11,991	0	90.00
91.00	09100	EMERGENCY	264,355	346,098	9,469	135,917	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,755,837	1,531,359	1,973,131	1,765,391	270,182	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	4,313	5,779	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,760,150	1,537,138	1,973,131	1,765,391	270,182	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	10,167,265	0	10,167,265		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,393,393	0	2,393,393		31.00
43.00	04300	NURSERY	0	755,492	0	755,492		43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,486,528	0	2,486,528		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,802,366	0	12,802,366		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	261,141	0	261,141		52.00
53.00	05300	ANESTHESIOLOGY	0	742,016	0	742,016		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,648,318	0	8,648,318		54.00
60.00	06000	LABORATORY	0	6,786,201	0	6,786,201		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,584,371	0	2,584,371		65.00
66.00	06600	PHYSICAL THERAPY	0	4,608,700	0	4,608,700		66.00
68.00	06800	SPEECH PATHOLOGY	0	348,840	0	348,840		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	24,557	0	24,557		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,002,522	0	1,002,522		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,259,288	0	2,259,288		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,182,408	0	5,182,408		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	419,157	0	419,157		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	258,733	0	258,733		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,080,554	0	1,080,554		90.00
91.00	09100	EMERGENCY	0	8,805,315	0	8,805,315		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	71,617,165	0	71,617,165		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	97,850	0	97,850		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	870,577	0	870,577		192.00
192.01	19201	RENTED SPACE	0	953,030	0	953,030		192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	73,538,622	0	73,538,622		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	93,035	52,178	145,213	145,213	4.00
5.01	00540	NONPATIENT TELEPHONES	0	12,509	0	12,509	0	5.01
5.02	00550	DATA PROCESSING	0	44,786	515,964	560,750	4,237	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	108,795	0	108,795	1,384	5.03
5.04	00570	ADMITTING	0	15,413	770	16,183	2,973	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	30,069	0	30,069	3,241	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	3,531	311,322	66,652	381,505	14,334	5.06
7.00	00700	OPERATION OF PLANT	1,296	505,662	64,413	571,371	4,619	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	84,187	11,838	96,025	973	8.00
9.00	00900	HOUSEKEEPING	0	161,703	3,775	165,478	3,924	9.00
10.00	01000	DIETARY	0	94,850	30,180	125,030	1,345	10.00
11.00	01100	CAFETERIA	0	61,786	0	61,786	3,487	11.00
13.00	01300	NURSING ADMINISTRATION	0	16,577	3,212	19,789	2,619	13.00
15.00	01500	PHARMACY	3,660	39,598	6,405	49,663	3,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,436	0	54,436	2,736	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	545	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,507	452,924	106,848	585,279	16,903	30.00
31.00	03100	INTENSIVE CARE UNIT	5,648	81,706	31,040	118,394	4,505	31.00
43.00	04300	NURSERY	0	11,752	0	11,752	1,495	43.00
44.00	04400	SKILLED NURSING FACILITY	4,422	102,171	10,640	117,233	3,474	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,914	269,924	779,498	1,144,336	17,261	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,125	0	24,125	374	52.00
53.00	05300	ANESTHESIOLOGY	11,835	15,715	80,784	108,334	204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	198,261	1,071,226	1,269,487	9,995	54.00
60.00	06000	LABORATORY	991	127,384	93,239	221,614	8,240	60.00
65.00	06500	RESPIRATORY THERAPY	2,912	71,315	56,947	131,174	3,136	65.00
66.00	06600	PHYSICAL THERAPY	2,775	142,464	17,194	162,433	9,828	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,734	664	5,398	807	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,464	3,617	7,081	23	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49	78,832	71,806	150,687	521	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,706	0	3,706	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	289	44,892	5,387	50,568	605	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	19,239	11,250	30,489	405	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	39,855	12,822	52,677	2,007	90.00
91.00	09100	EMERGENCY	13,455	312,048	184,348	509,851	15,554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	171,284	3,639,239	3,292,697	7,103,220	144,978	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,481	0	19,481	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,906	120,869	122,775	235	192.00
192.01	19201	RENTED SPACE	0	349,271	0	349,271	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	171,284	4,009,897	3,413,566	7,594,747	145,213	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	12,509					5.01
5.02	00550	DATA PROCESSING	548	565,535				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	197	7,742	118,118			5.03
5.04	00570	ADMITTING	337	7,742	1,768	29,003		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	309	77,475	7,278	0	118,372	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,519	38,736	15,890	0	0	5.06
7.00	00700	OPERATION OF PLANT	590	0	9,670	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56	0	11,086	0	0	8.00
9.00	00900	HOUSEKEEPING	56	0	18,719	0	0	9.00
10.00	01000	DIETARY	211	38,736	3,759	0	0	10.00
11.00	01100	CAFETERIA	0	0	13,600	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	225	7,742	493	0	0	13.00
15.00	01500	PHARMACY	197	15,485	1,560	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	281	77,473	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	56	7,742	2,507	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	914	23,251	2,016	1,587	6,486	30.00
31.00	03100	INTENSIVE CARE UNIT	155	15,485	430	517	2,114	31.00
43.00	04300	NURSERY	98	0	131	127	518	43.00
44.00	04400	SKILLED NURSING FACILITY	169	23,251	482	382	1,562	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,307	7,742	8,636	5,325	21,771	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28	0	33	134	547	52.00
53.00	05300	ANESTHESIOLOGY	647	0	336	632	2,585	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	548	38,736	3,204	7,888	32,048	54.00
60.00	06000	LABORATORY	534	61,988	7,394	3,418	13,974	60.00
65.00	06500	RESPIRATORY THERAPY	253	61,988	3,775	1,784	7,294	65.00
66.00	06600	PHYSICAL THERAPY	590	15,485	1,035	1,403	5,735	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	86	66	270	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	6	11	44	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	493	520	2,126	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	608	2,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,050	8,381	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	56	0	383	43	177	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	85	85	348	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	323	0	400	196	803	90.00
91.00	09100	EMERGENCY	1,138	23,251	2,799	2,227	9,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,342	550,050	118,054	29,003	118,372	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	253	15,485	64	0	0	192.00
192.01	19201	RENTED SPACE	914	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,509	565,535	118,118	29,003	118,372	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	451,984					5.06
7.00	00700	OPERATION OF PLANT	27,788	614,038				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,090	17,898	130,128			8.00
9.00	00900	HOUSEKEEPING	11,400	34,377	4,220	238,174		9.00
10.00	01000	DIETARY	7,102	20,165	1,002	0	197,350	10.00
11.00	01100	CAFETERIA	10,225	13,135	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,263	3,524	0	51,148	0	13.00
15.00	01500	PHARMACY	11,229	8,418	0	5,018	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,800	11,573	0	2,970	0	16.00
17.00	01700	SOCIAL SERVICE	1,585	0	0	481	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,771	96,291	29,799	19,977	133,289	30.00
31.00	03100	INTENSIVE CARE UNIT	11,741	17,370	3,319	5,018	10,640	31.00
43.00	04300	NURSERY	3,643	2,498	1,592	5,454	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,661	21,721	7,373	8,364	53,421	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,531	57,384	41,130	20,132	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,136	5,129	398	1,361	0	52.00
53.00	05300	ANESTHESIOLOGY	3,561	3,341	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,943	42,149	9,174	9,445	0	54.00
60.00	06000	LABORATORY	37,830	27,081	46	7,030	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,709	15,161	498	6,563	0	65.00
66.00	06600	PHYSICAL THERAPY	24,599	30,287	3,329	16,287	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,828	1,006	0	3,575	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	111	736	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,873	16,759	0	3,364	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,659	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,154	788	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,903	9,544	24	2,204	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,337	4,090	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,760	8,473	0	0	0	90.00
91.00	09100	EMERGENCY	44,042	66,340	27,602	25,302	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	446,274	535,238	129,506	193,693	197,350	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	138	4,142	0	5,018	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,074	405	622	39,463	0	192.00
192.01	19201	RENTED SPACE	2,498	74,253	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	451,984	614,038	130,128	238,174	197,350	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	102,233					11.00
13.00	01300	NURSING ADMINISTRATION	1,975	93,778				13.00
15.00	01500	PHARMACY	2,284	0	97,078			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,435	0	0	162,704		16.00
17.00	01700	SOCIAL SERVICE	460	0	0	0	13,376	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,363	32,528	35	8,928	7,979	30.00
31.00	03100	INTENSIVE CARE UNIT	3,656	6,283	6	2,910	1,081	31.00
43.00	04300	NURSERY	1,289	2,474	6	713	750	43.00
44.00	04400	SKILLED NURSING FACILITY	3,805	7,273	0	2,150	3,566	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,907	19,635	1,735	29,968	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	323	618	2	753	0	52.00
53.00	05300	ANESTHESIOLOGY	3,008	0	2,343	3,558	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,934	623	4,033	43,877	0	54.00
60.00	06000	LABORATORY	9,214	0	88	19,236	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,385	36	634	10,041	0	65.00
66.00	06600	PHYSICAL THERAPY	7,655	0	0	7,894	0	66.00
68.00	06800	SPEECH PATHOLOGY	463	0	0	372	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25	0	0	61	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	925	0	422	2,926	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,419	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	87,217	11,536	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	458	545	0	244	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	348	0	0	479	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,717	2,295	91	1,106	0	90.00
91.00	09100	EMERGENCY	15,354	21,115	466	12,533	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	101,983	93,425	97,078	162,704	13,376	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	250	353	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	102,233	93,778	97,078	162,704	13,376	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,026,396	0	1,026,396		30.00
31.00	03100	INTENSIVE CARE UNIT		203,624	0	203,624		31.00
43.00	04300	NURSERY		32,540	0	32,540		43.00
44.00	04400	SKILLED NURSING FACILITY		263,887	0	263,887		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		1,459,800	0	1,459,800		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		34,961	0	34,961		52.00
53.00	05300	ANESTHESIOLOGY		128,549	0	128,549		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,526,084	0	1,526,084		54.00
60.00	06000	LABORATORY		417,687	0	417,687		60.00
65.00	06500	RESPIRATORY THERAPY		259,431	0	259,431		65.00
66.00	06600	PHYSICAL THERAPY		286,560	0	286,560		66.00
68.00	06800	SPEECH PATHOLOGY		13,871	0	13,871		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		8,098	0	8,098		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		183,616	0	183,616		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		20,170	0	20,170		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		133,832	0	133,832		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		66,754	0	66,754		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		37,666	0	37,666		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		75,848	0	75,848		90.00
91.00	09100	EMERGENCY		776,679	0	776,679		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	6,956,053	0	6,956,053		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		28,779	0	28,779		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		182,979	0	182,979		192.00
192.01	19201	RENTED SPACE		426,936	0	426,936		192.01
194.00	07950	FUND DEVELOPMENT		0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	7,594,747	0	7,594,747		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	265,114					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,584,263				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,151	39,502	33,167,160			4.00
5.01	00540	NONPATIENT TELEPHONES	827	0	0	890		5.01
5.02	00550	DATA PROCESSING	2,961	390,614	967,887	39	23,593	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	7,193	0	316,190	14	323	5.03
5.04	00570	ADMITTING	1,019	583	679,138	24	323	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,988	0	740,361	22	3,232	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	20,583	50,459	3,274,208	108	1,616	5.06
7.00	00700	OPERATION OF PLANT	33,432	48,764	1,055,011	42	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,566	8,962	222,330	4	0	8.00
9.00	00900	HOUSEKEEPING	10,691	2,858	896,404	4	0	9.00
10.00	01000	DIETARY	6,271	22,848	307,178	15	1,616	10.00
11.00	01100	CAFETERIA	4,085	0	796,586	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,096	2,432	598,304	16	323	13.00
15.00	01500	PHARMACY	2,618	4,849	736,513	14	646	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,599	0	624,874	20	3,232	16.00
17.00	01700	SOCIAL SERVICE	0	0	124,510	4	323	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,945	80,890	3,860,940	65	970	30.00
31.00	03100	INTENSIVE CARE UNIT	5,402	23,499	1,029,035	11	646	31.00
43.00	04300	NURSERY	777	0	341,438	7	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,755	8,055	793,514	12	970	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,846	590,124	3,940,590	93	323	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	0	85,359	2	0	52.00
53.00	05300	ANESTHESIOLOGY	1,039	61,158	46,553	46	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,108	810,979	2,283,054	39	1,616	54.00
60.00	06000	LABORATORY	8,422	70,587	1,882,130	38	2,586	60.00
65.00	06500	RESPIRATORY THERAPY	4,715	43,112	716,272	18	2,586	65.00
66.00	06600	PHYSICAL THERAPY	9,419	13,017	2,244,752	42	646	66.00
68.00	06800	SPEECH PATHOLOGY	313	503	184,271	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	229	2,738	5,316	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,212	54,361	118,968	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	245	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,968	4,078	138,222	4	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,272	8,517	92,462	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,635	9,707	458,415	23	0	90.00
91.00	09100	EMERGENCY	20,631	139,562	3,552,760	81	970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	240,608	2,492,758	33,113,545	807	22,947	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126	91,505	53,615	18	646	192.00
192.01	19201	RENTED SPACE	23,092	0	0	65	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,009,897	3,413,566	9,954,137	56,143	3,390,858	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.125180	1.320905	0.300120	63.082022	143.723053	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			145,213	12,509	565,535	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.004378	14.055056	23.970457	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,136,201					5.03
5.04	00570	ADMITTING	17,010	283,590,006				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	70,005	0	283,590,006			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	152,848	0	0	-9,586,325	63,952,297	5.06
7.00	00700	OPERATION OF PLANT	93,021	0	0	0	3,931,531	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	106,636	0	0	0	578,678	8.00
9.00	00900	HOUSEKEEPING	180,054	0	0	0	1,612,952	9.00
10.00	01000	DIETARY	36,162	0	0	0	1,004,838	10.00
11.00	01100	CAFETERIA	130,822	0	0	0	1,446,598	11.00
13.00	01300	NURSING ADMINISTRATION	4,739	0	0	0	886,146	13.00
15.00	01500	PHARMACY	15,009	0	0	0	1,588,729	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,386,600	16.00
17.00	01700	SOCIAL SERVICE	24,116	0	0	0	224,320	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,396	15,554,672	15,554,672	0	6,192,845	30.00
31.00	03100	INTENSIVE CARE UNIT	4,134	5,069,020	5,069,020	0	1,661,164	31.00
43.00	04300	NURSERY	1,264	1,242,452	1,242,452	0	515,476	43.00
44.00	04400	SKILLED NURSING FACILITY	4,636	3,744,781	3,744,781	0	1,366,922	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	83,075	52,209,539	52,209,539	0	9,558,729	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	316	1,311,365	1,311,365	0	160,764	52.00
53.00	05300	ANESTHESIOLOGY	3,230	6,199,071	6,199,071	0	503,884	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,822	76,576,400	76,576,400	0	6,500,087	54.00
60.00	06000	LABORATORY	71,128	33,511,760	33,511,760	0	5,352,228	60.00
65.00	06500	RESPIRATORY THERAPY	36,312	17,492,195	17,492,195	0	1,939,520	65.00
66.00	06600	PHYSICAL THERAPY	9,952	13,752,746	13,752,746	0	3,480,312	66.00
68.00	06800	SPEECH PATHOLOGY	829	647,608	647,608	0	258,641	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	53	105,781	105,781	0	15,698	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,738	5,097,675	5,097,675	0	689,413	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,956,616	5,956,616	0	1,932,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,098,309	20,098,309	0	2,851,383	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,687	424,862	424,862	0	269,186	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	821	834,897	834,897	0	189,094	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,844	1,926,197	1,926,197	0	814,983	90.00
91.00	09100	EMERGENCY	26,927	21,834,060	21,834,060	0	6,231,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,135,586	283,590,006	283,590,006	-9,586,325	63,144,483	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	19,481	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	615	0	0	0	434,962	192.00
192.01	19201	RENTED SPACE	0	0	0	0	353,371	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	717,317	976,286	2,054,042		9,586,325	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.631329	0.003443	0.007243		0.149898	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	118,118	29,003	118,372		451,984	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.103959	0.000102	0.000417		0.007068	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	190,960					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,566	1,074,260				8.00
9.00	00900	HOUSEKEEPING	10,691	34,838	51,971			9.00
10.00	01000	DIETARY	6,271	8,275	0	41,845		10.00
11.00	01100	CAFETERIA	4,085	0	0	0	45,303	11.00
13.00	01300	NURSING ADMINISTRATION	1,096	0	11,161	0	875	13.00
15.00	01500	PHARMACY	2,618	0	1,095	0	1,012	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,599	0	648	0	1,522	16.00
17.00	01700	SOCIAL SERVICE	0	0	105	0	204	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,945	246,003	4,359	28,262	7,695	30.00
31.00	03100	INTENSIVE CARE UNIT	5,402	27,396	1,095	2,256	1,620	31.00
43.00	04300	NURSERY	777	13,139	1,190	0	571	43.00
44.00	04400	SKILLED NURSING FACILITY	6,755	60,868	1,825	11,327	1,686	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,846	339,543	4,393	0	7,049	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	3,285	297	0	143	52.00
53.00	05300	ANESTHESIOLOGY	1,039	0	0	0	1,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,108	75,737	2,061	0	3,959	54.00
60.00	06000	LABORATORY	8,422	376	1,534	0	4,083	60.00
65.00	06500	RESPIRATORY THERAPY	4,715	4,114	1,432	0	1,500	65.00
66.00	06600	PHYSICAL THERAPY	9,419	27,485	3,554	0	3,392	66.00
68.00	06800	SPEECH PATHOLOGY	313	0	780	0	205	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	229	0	0	0	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,212	0	734	0	410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	245	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,968	195	481	0	203	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,272	0	0	0	154	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,635	0	0	0	761	90.00
91.00	09100	EMERGENCY	20,631	227,868	5,521	0	6,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	166,454	1,069,122	42,265	41,845	45,192	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	1,095	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126	5,138	8,611	0	111	192.00
192.01	19201	RENTED SPACE	23,092	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,520,860	797,193	2,133,686	1,310,064	1,760,150	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.674382	0.742086	41.055319	31.307540	38.852835	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	614,038	130,128	238,174	197,350	102,233	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.215532	0.121133	4.582825	4.716215	2.256650	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/15/2016 10:39 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	15.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	364,927					13.00
15.00	01500	PHARMACY	0	2,930,606				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	283,590,006			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	14,124		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	126,582	1,043	15,554,672	8,426	0	30.00
31.00	03100	INTENSIVE CARE UNIT	24,448	173	5,069,020	1,141	0	31.00
43.00	04300	NURSERY	9,626	194	1,242,452	792	0	43.00
44.00	04400	SKILLED NURSING FACILITY	28,304	15	3,744,781	3,765	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	76,407	52,374	52,209,539	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,406	49	1,311,365	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	70,733	6,199,071	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,426	121,747	76,576,400	0	0	54.00
60.00	06000	LABORATORY	0	2,665	33,511,760	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	140	19,151	17,492,195	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	13,752,746	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	647,608	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	105,781	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,740	5,097,675	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,956,616	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,632,907	20,098,309	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,120	0	424,862	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	834,897	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,930	2,751	1,926,197	0	0	90.00
91.00	09100	EMERGENCY	82,166	14,064	21,834,060	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	363,555	2,930,606	283,590,006	14,124	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,372	0	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,537,138	1,973,131	1,765,391	270,182	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.212179	0.673284	0.006225	19.129283	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	93,778	97,078	162,704	13,376	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.256977	0.033126	0.000574	0.947040	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2016 10:39 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,167,265		10,167,265	0	10,167,265	30.00
31.00	03100	INTENSIVE CARE UNIT	2,393,393		2,393,393	0	2,393,393	31.00
43.00	04300	NURSERY	755,492		755,492	0	755,492	43.00
44.00	04400	SKILLED NURSING FACILITY	2,486,528		2,486,528	0	2,486,528	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,802,366		12,802,366	0	12,802,366	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	261,141		261,141	0	261,141	52.00
53.00	05300	ANESTHESIOLOGY	742,016		742,016	0	742,016	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,648,318		8,648,318	0	8,648,318	54.00
60.00	06000	LABORATORY	6,786,201		6,786,201	0	6,786,201	60.00
65.00	06500	RESPIRATORY THERAPY	2,584,371	0	2,584,371	1,222	2,585,593	65.00
66.00	06600	PHYSICAL THERAPY	4,608,700	0	4,608,700	0	4,608,700	66.00
68.00	06800	SPEECH PATHOLOGY	348,840	0	348,840	0	348,840	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,557		24,557	0	24,557	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,002,522		1,002,522	0	1,002,522	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,259,288		2,259,288	0	2,259,288	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,182,408		5,182,408	0	5,182,408	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	419,157		419,157	0	419,157	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	258,733		258,733	0	258,733	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,080,554		1,080,554	0	1,080,554	90.00
91.00	09100	EMERGENCY	8,805,315		8,805,315	0	8,805,315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	821,858		821,858		821,858	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	72,439,023	0	72,439,023	1,222	72,440,245	200.00
201.00		Less Observation Beds	821,858		821,858		821,858	201.00
202.00		Total (see instructions)	71,617,165	0	71,617,165	1,222	71,618,387	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2016 10:39 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,618,544		14,618,544			30.00
31.00	03100	INTENSIVE CARE UNIT	5,069,020		5,069,020			31.00
43.00	04300	NURSERY	1,242,452		1,242,452			43.00
44.00	04400	SKILLED NURSING FACILITY	3,744,781		3,744,781			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,673,504	38,536,035	52,209,539	0.245211	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,018,165	293,200	1,311,365	0.199137	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,969,362	4,229,709	6,199,071	0.119698	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,625,578	69,950,822	76,576,400	0.112937	0.000000	54.00
60.00	06000	LABORATORY	10,244,347	23,267,413	33,511,760	0.202502	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,027,403	8,464,792	17,492,195	0.147744	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,040,612	9,712,134	13,752,746	0.335111	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	139,504	508,104	647,608	0.538659	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,560	102,221	105,781	0.232149	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,154,222	1,943,453	5,097,675	0.196663	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,175,406	1,781,210	5,956,616	0.379291	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,061,664	11,036,645	20,098,309	0.257853	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	6,363	418,499	424,862	0.986572	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	834,897	834,897	0.309898	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55,481	1,870,716	1,926,197	0.560978	0.000000	90.00
91.00	09100	EMERGENCY	3,007,080	18,826,980	21,834,060	0.403283	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	82,463	853,665	936,128	0.877933	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	90,959,511	192,630,495	283,590,006			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	90,959,511	192,630,495	283,590,006			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2016 10:39 am

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
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.245211	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.199137	52.00
53.00	05300	ANESTHESIOLOGY	0.119698	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112937	54.00
60.00	06000	LABORATORY	0.202502	60.00
65.00	06500	RESPIRATORY THERAPY	0.147814	65.00
66.00	06600	PHYSICAL THERAPY	0.335111	66.00
68.00	06800	SPEECH PATHOLOGY	0.538659	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232149	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196663	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.379291	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257853	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.986572	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309898	76.98
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.560978	90.00
91.00	09100	EMERGENCY	0.403283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.877933	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2016 10:39 am

Title XIX | Hospital

		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	10,167,265		10,167,265	0	10,167,265	30.00
31.00	03100	INTENSIVE CARE UNIT	2,393,393		2,393,393	0	2,393,393	31.00
43.00	04300	NURSERY	755,492		755,492	0	755,492	43.00
44.00	04400	SKILLED NURSING FACILITY	2,486,528		2,486,528	0	2,486,528	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,802,366		12,802,366	0	12,802,366	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	261,141		261,141	0	261,141	52.00
53.00	05300	ANESTHESIOLOGY	742,016		742,016	0	742,016	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,648,318		8,648,318	0	8,648,318	54.00
60.00	06000	LABORATORY	6,786,201		6,786,201	0	6,786,201	60.00
65.00	06500	RESPIRATORY THERAPY	2,584,371	0	2,584,371	1,222	2,585,593	65.00
66.00	06600	PHYSICAL THERAPY	4,608,700	0	4,608,700	0	4,608,700	66.00
68.00	06800	SPEECH PATHOLOGY	348,840	0	348,840	0	348,840	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,557		24,557	0	24,557	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,002,522		1,002,522	0	1,002,522	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,259,288		2,259,288	0	2,259,288	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,182,408		5,182,408	0	5,182,408	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	419,157		419,157	0	419,157	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	258,733		258,733	0	258,733	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,080,554		1,080,554	0	1,080,554	90.00
91.00	09100	EMERGENCY	8,805,315		8,805,315	0	8,805,315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	821,858		821,858		821,858	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	72,439,023	0	72,439,023	1,222	72,440,245	200.00
201.00		Less Observation Beds	821,858		821,858		821,858	201.00
202.00		Total (see instructions)	71,617,165	0	71,617,165	1,222	71,618,387	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2016 10:39 am

Title XIX | Hospital

		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	14,618,544		14,618,544			30.00
31.00	03100	INTENSIVE CARE UNIT	5,069,020		5,069,020			31.00
43.00	04300	NURSERY	1,242,452		1,242,452			43.00
44.00	04400	SKILLED NURSING FACILITY	3,744,781		3,744,781			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,673,504	38,536,035	52,209,539	0.245211	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,018,165	293,200	1,311,365	0.199137	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,969,362	4,229,709	6,199,071	0.119698	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,625,578	69,950,822	76,576,400	0.112937	0.000000	54.00
60.00	06000	LABORATORY	10,244,347	23,267,413	33,511,760	0.202502	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,027,403	8,464,792	17,492,195	0.147744	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,040,612	9,712,134	13,752,746	0.335111	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	139,504	508,104	647,608	0.538659	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,560	102,221	105,781	0.232149	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,154,222	1,943,453	5,097,675	0.196663	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,175,406	1,781,210	5,956,616	0.379291	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,061,664	11,036,645	20,098,309	0.257853	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	6,363	418,499	424,862	0.986572	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	834,897	834,897	0.309898	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55,481	1,870,716	1,926,197	0.560978	0.000000	90.00
91.00	09100	EMERGENCY	3,007,080	18,826,980	21,834,060	0.403283	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	82,463	853,665	936,128	0.877933	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	90,959,511	192,630,495	283,590,006			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	90,959,511	192,630,495	283,590,006			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/15/2016 10:39 am

Title XIX | Hospital

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,026,396	0	1,026,396	9,167	111.97	30.00
31.00	INTENSIVE CARE UNIT	203,624		203,624	1,141	178.46	31.00
43.00	NURSERY	32,540		32,540	792	41.09	43.00
44.00	SKILLED NURSING FACILITY	263,887		263,887	3,765	70.09	44.00
200.00	Total (lines 30-199)	1,526,447		1,526,447	14,865		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	4,763	533,313				30.00
31.00	INTENSIVE CARE UNIT	736	131,347				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,087	216,368				44.00
200.00	Total (lines 30-199)	8,586	881,028				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,459,800	52,209,539	0.027960	6,346,006	177,434	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,961	1,311,365	0.026660	17,776	474	52.00
53.00	05300	ANESTHESIOLOGY	128,549	6,199,071	0.020737	505,793	10,489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,526,084	76,576,400	0.019929	5,561,080	110,827	54.00
60.00	06000	LABORATORY	417,687	33,511,760	0.012464	5,866,957	73,126	60.00
65.00	06500	RESPIRATORY THERAPY	259,431	17,492,195	0.014831	5,357,460	79,456	65.00
66.00	06600	PHYSICAL THERAPY	286,560	13,752,746	0.020837	1,369,877	28,544	66.00
68.00	06800	SPEECH PATHOLOGY	13,871	647,608	0.021419	67,861	1,454	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,098	105,781	0.076554	1,187	91	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	183,616	5,097,675	0.036020	1,238,330	44,605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,170	5,956,616	0.003386	2,352,633	7,966	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	133,832	20,098,309	0.006659	6,016,153	40,062	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	66,754	424,862	0.157119	197	31	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	37,666	834,897	0.045115	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	75,848	1,926,197	0.039377	26,094	1,028	90.00
91.00	09100	EMERGENCY	776,679	21,834,060	0.035572	1,675,404	59,597	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	82,967	936,128	0.088628	52,349	4,640	92.00
200.00		Total (lines 50-199)	5,512,573	258,915,209		36,455,157	639,824	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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	9,167	0.00	4,763	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,141	0.00	736	0		31.00
43.00	04300	NURSERY	792	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	3,765	0.00	3,087	0		44.00
200.00		Total (lines 30-199)	14,865		8,586	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	52,209,539	0.000000	0.000000	6,346,006	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,311,365	0.000000	0.000000	17,776	52.00
53.00	05300	ANESTHESIOLOGY	0	6,199,071	0.000000	0.000000	505,793	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	76,576,400	0.000000	0.000000	5,561,080	54.00
60.00	06000	LABORATORY	0	33,511,760	0.000000	0.000000	5,866,957	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,492,195	0.000000	0.000000	5,357,460	65.00
66.00	06600	PHYSICAL THERAPY	0	13,752,746	0.000000	0.000000	1,369,877	66.00
68.00	06800	SPEECH PATHOLOGY	0	647,608	0.000000	0.000000	67,861	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	105,781	0.000000	0.000000	1,187	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,097,675	0.000000	0.000000	1,238,330	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,956,616	0.000000	0.000000	2,352,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,098,309	0.000000	0.000000	6,016,153	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	424,862	0.000000	0.000000	197	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	834,897	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,926,197	0.000000	0.000000	26,094	90.00
91.00	09100	EMERGENCY	0	21,834,060	0.000000	0.000000	1,675,404	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	936,128	0.000000	0.000000	52,349	92.00
200.00		Total (lines 50-199)	0	258,915,209			36,455,157	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	10,655,307	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	843,916	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,951,937	0		54.00
60.00	06000	LABORATORY	0	5,310,547	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,146,823	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,867	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,120	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	674,561	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	554,798	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,267,171	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	207,185	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	277,091	0		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	876,503	0		90.00
91.00	09100	EMERGENCY	0	4,776,328	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	534,900	0		92.00
200.00		Total (lines 50-199)	0	54,087,054	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.245211	10,655,307	0	0	2,612,798	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.199137	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.119698	843,916	0	0	101,015	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112937	21,951,937	1,350	0	2,479,186	54.00
60.00	06000	LABORATORY	0.202502	5,310,547	234	0	1,075,396	60.00
65.00	06500	RESPIRATORY THERAPY	0.147744	2,146,823	0	0	317,180	65.00
66.00	06600	PHYSICAL THERAPY	0.335111	2,867	0	0	961	66.00
68.00	06800	SPEECH PATHOLOGY	0.538659	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232149	7,120	0	0	1,653	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196663	674,561	266	0	132,661	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.379291	554,798	0	0	210,430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257853	5,267,171	0	74,463	1,358,156	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.986572	207,185	0	0	204,403	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309898	277,091	0	0	85,870	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.560978	876,503	1,828	0	491,699	90.00
91.00	09100	EMERGENCY	0.403283	4,776,328	0	0	1,926,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.877933	534,900	0	0	469,606	92.00
200.00		Subtotal (see instructions)		54,087,054	3,678	74,463	11,467,226	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		54,087,054	3,678	74,463	11,467,226	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	152	0		54.00
60.00	06000	LABORATORY	47	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,201		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1,025	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	1,276	19,201		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,276	19,201		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/15/2016 10:39 am

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/15/2016 10:39 am

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	52,209,539	0.000000	0.000000	1,191	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,311,365	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	6,199,071	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	76,576,400	0.000000	0.000000	94,690	54.00
60.00	06000	LABORATORY	0	33,511,760	0.000000	0.000000	448,266	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,492,195	0.000000	0.000000	1,258,504	65.00
66.00	06600	PHYSICAL THERAPY	0	13,752,746	0.000000	0.000000	1,699,815	66.00
68.00	06800	SPEECH PATHOLOGY	0	647,608	0.000000	0.000000	44,939	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	105,781	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,097,675	0.000000	0.000000	220,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,956,616	0.000000	0.000000	1,693	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,098,309	0.000000	0.000000	789,185	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	424,862	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	834,897	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,926,197	0.000000	0.000000	20,596	90.00
91.00	09100	EMERGENCY	0	21,834,060	0.000000	0.000000	8,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	936,128	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	258,915,209			4,587,643	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/15/2016 10:39 am

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Skilled Nursing Facility | 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	0.245211	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.199137	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.119698	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112937	0	0	0	0	54.00
60.00	06000	LABORATORY	0.202502	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.147744	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.335111	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.538659	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232149	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196663	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.379291	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257853	0	0	1,969	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.986572	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309898	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.560978	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.403283	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.877933	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	1,969	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	1,969	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Skilled Nursing Facility | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	508		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	508		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	508		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,167	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,167	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)	8,426	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)	4,763	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)	10,167,265	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)	10,167,265	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)	10,167,265	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)	1,109.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,282,739	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)	5,282,739	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,393,393	1,141	2,097.63	736	1,543,856	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)	8,147,717	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,974,312	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)	664,660	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	639,824	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,304,484	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,669,828	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)	741	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,109.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	821,858	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,026,396	10,167,265	0.100951	821,858	82,967	90.00
91.00	Nursing School cost	0	10,167,265	0.000000	821,858	0	91.00
92.00	Allied health cost	0	10,167,265	0.000000	821,858	0	92.00
93.00	All other Medical Education	0	10,167,265	0.000000	821,858	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140058 Component CCN: 145951	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/15/2016 10:39 am
	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)	3,765	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,765	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)	3,765	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,087	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)	2,486,528	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)	2,486,528	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)	2,486,528	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: 140058 | Component CCN: 145951 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2016 10:39 am

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)	2,486,528	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	660.43	71.00
72.00	Program routine service cost (line 9 x line 71)	2,038,747	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)	2,038,747	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)	2,038,747	83.00
84.00	Program inpatient ancillary services (see instructions)	1,143,943	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)	3,182,690	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: 140058 | Component CCN: 145951 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/15/2016 10:39 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/15/2016 10:39 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,569,326		30.00
31.00	03100	INTENSIVE CARE UNIT		3,250,458		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.245211	6,346,006	1,556,110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.199137	17,776	3,540	52.00
53.00	05300	ANESTHESIOLOGY	0.119698	505,793	60,542	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112937	5,561,080	628,052	54.00
60.00	06000	LABORATORY	0.202502	5,866,957	1,188,071	60.00
65.00	06500	RESPIRATORY THERAPY	0.147814	5,357,460	791,908	65.00
66.00	06600	PHYSICAL THERAPY	0.335111	1,369,877	459,061	66.00
68.00	06800	SPEECH PATHOLOGY	0.538659	67,861	36,554	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232149	1,187	276	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196663	1,238,330	243,534	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.379291	2,352,633	892,333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257853	6,016,153	1,551,283	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.986572	197	194	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309898	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.560978	26,094	14,638	90.00
91.00	09100	EMERGENCY	0.403283	1,675,404	675,662	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.877933	52,349	45,959	92.00
200.00		Total (sum of lines 50-94 and 96-98)		36,455,157	8,147,717	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)		36,455,157		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/15/2016 10:39 am

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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.245211	1,191	292	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.199137	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.119698	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.112937	94,690	10,694	54.00
60.00	06000	LABORATORY	0.202502	448,266	90,775	60.00
65.00	06500	RESPIRATORY THERAPY	0.147744	1,258,504	185,936	65.00
66.00	06600	PHYSICAL THERAPY	0.335111	1,699,815	569,627	66.00
68.00	06800	SPEECH PATHOLOGY	0.538659	44,939	24,207	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.232149	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.196663	220,379	43,340	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.379291	1,693	642	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257853	789,185	203,494	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.986572	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309898	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.560978	20,596	11,554	90.00
91.00	09100	EMERGENCY	0.403283	8,385	3,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.877933	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,587,643	1,143,943	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)		4,587,643		202.00

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,355,918			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)		282,512			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)		90.97			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

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.23			30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.38			31.00
32.00	Sum of lines 30 and 31		23.61			32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.69			33.00
34.00	Disproportionate share adjustment (see instructions)		203,257			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000042292	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		323,434	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		323,434	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		323,434			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		10,165,121			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		11,732,646			48.00
49.00	Total payment for inpatient operating costs (see instructions)		11,732,646			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		780,850			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		12,513,496			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,513,496			61.00
62.00	Deductibles billed to program beneficiaries		1,393,620			62.00

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		11,263			63.00
64.00	Allowable bad debts (see instructions)		357,233			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		232,201			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		318,016			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,340,814			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)		-11,999			70.93
70.94	HRR adjustment amount (see instructions)		-14,970			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,313,845			71.00
71.01	Sequestration adjustment (see instructions)		226,277			71.01
72.00	Interim payments		11,233,436			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)		-145,868			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140058	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/15/2016 10:39 am
	Title XVIII	Hospital	PPS

		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)			0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140058	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/15/2016 10:39 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	20,477	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,467,226	2.00
3.00	PPS payments	9,092,141	3.00
4.00	Outlier payment (see instructions)	28,621	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)	20,477	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	78,141	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)	78,141	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)	78,141	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	57,664	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)	20,477	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)	9,120,762	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	516	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,037,506	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,103,217	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	7,103,217	30.00
31.00	Primary payer payments	1,093	31.00
32.00	Subtotal (line 30 minus line 31)	7,102,124	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)	625,698	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	406,704	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	556,826	36.00
37.00	Subtotal (see instructions)	7,508,828	37.00
38.00	MSP-LCC reconciliation amount from PS&R	702	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	7,508,126	40.00
40.01	Sequestration adjustment (see instructions)	150,163	40.01
41.00	Interim payments	7,257,773	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	100,190	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: 140058 Component CCN: 145951	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/15/2016 10:39 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	508	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	508	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,969	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)	1,969	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)	1,969	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,461	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)	508	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	508	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)	508	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	508	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)	508	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	508	40.00
40.01	Sequestration adjustment (see instructions)	10	40.01
41.00	Interim payments	444	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	54	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 2/15/2016 10:39 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,305,762		7,261,154	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	05/21/2015	72,326	05/21/2015	3,381	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)		-72,326		-3,381	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11,233,436		7,257,773	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		100,190	6.01
6.02	SETTLEMENT TO PROGRAM		145,868		0	6.02
7.00	Total Medicare program liability (see instructions)		11,087,568		7,357,963	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: 140058 Component CCN: 145951	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part I Date/Time Prepared: 2/15/2016 10:39 am
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		1,043,960		444	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)		1,043,960		444	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		54	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,043,960		498	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: 140058	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/15/2016 10:39 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	3,023	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	5,499	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	587	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	9,567	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	283,590,006	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,986,754	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)	766,111	8.00
9.00	Sequestration adjustment amount (see instructions)	15,322	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	750,789	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	750,789	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140058 Component CCN: 145951	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 2/15/2016 10:39 am
	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)	1,129,939	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)	1,129,939	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	64,674	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)	1,065,265	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	1,065,265	15.00
15.01	Sequestration adjustment (see instructions)	21,305	15.01
16.00	Interim payments	1,043,960	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/15/2016 10:39 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,473,708	0	0	0	1.00
2.00	Temporary investments	9,227,903	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	46,664,235	0	0	0	4.00
5.00	Other receivable	11,348,933	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-34,918,879	0	0	0	6.00
7.00	Inventory	1,340,387	0	0	0	7.00
8.00	Prepaid expenses	1,173,428	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	39,309,715	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	975,458	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-58,322	0	0	0	14.00
15.00	Buildings	15,072,057	0	0	0	15.00
16.00	Accumulated depreciation	-604,743	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	13,288,716	0	0	0	19.00
20.00	Accumulated depreciation	-3,885,037	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,788,129	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	66,139,453	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	3,517,494	0	0	0	33.00
34.00	Other assets	22,748,907	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	92,405,854	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	156,503,698	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,610,498	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,217,990	0	0	0	38.00
39.00	Payroll taxes payable	2,906,638	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,631,927	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	5,830,708	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,197,761	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	25,602,944	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	8,439,544	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	34,042,488	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	50,240,249	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	106,263,449				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)	106,263,449	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	156,503,698	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/15/2016 10:39 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		123,476,936		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		21,069,083				2.00
3.00	Total (sum of line 1 and line 2)		144,546,019		0		3.00
4.00	TEMPORARILY RESTRICTED	892,543		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)		892,543		0		10.00
11.00	Subtotal (line 3 plus line 10)		145,438,562		0		11.00
12.00	UNRESTRICTED	17,693,153		0		0	12.00
13.00	PERMANENTLY RESTRICTED	412,877		0		0	13.00
14.00	NET INCOME	21,069,083		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)		39,175,113		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		106,263,449		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	TEMPORARILY RESTRICTED		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	UNRESTRICTED		0		12.00
13.00	PERMANENTLY RESTRICTED		0		13.00
14.00	NET INCOME		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: 140058 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/15/2016 10:39 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,322,252		14,322,252	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	5,605,330		5,605,330	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)	19,927,582		19,927,582	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,091,184		5,091,184	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)	5,091,184		5,091,184	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,018,766		25,018,766	17.00
18.00	Ancillary services	64,292,653	176,442,594	240,735,247	18.00
19.00	Outpatient services	3,175,743	22,165,441	25,341,184	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	226,666	226,666	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	92,487,162	198,834,701	291,321,863	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		77,563,436		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)		77,563,436		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140058	Period: From 10/01/2014 To 09/30/2015	Worksheet G-3 Date/Time Prepared: 2/15/2016 10:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	291,321,863	1.00
2.00	Less contractual allowances and discounts on patients' accounts	202,694,191	2.00
3.00	Net patient revenues (line 1 minus line 2)	88,627,672	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	77,563,436	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,064,236	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	352,204	6.00
7.00	Income from investments	3,349,443	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	470,264	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	32,158	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	12,018	21.00
22.00	Rental of hospital space	342,842	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	4,343,042	24.00
24.01	LIFELINE REVENUE	152,133	24.01
24.02	EHR INCENTIVE PAYMENTS	950,743	24.02
25.00	Total other income (sum of lines 6-24)	10,004,847	25.00
26.00	Total (line 5 plus line 25)	21,069,083	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	21,069,083	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140058	Period: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prepared: 2/15/2016 10:39 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	743,495	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	37,355	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)	27.33	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)	780,850	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