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: 140161	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/19/2016 2:57 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/19/2016 Time: 2:57 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 SAINT JAMES HOSPITAL (140161) 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	-387	10,585	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-387	10,585	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/19/2016 2:53 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2500 WEST REYNOLDS STREET	PO Box:			1.00
2.00	City: PONTIAC	State: IL	Zip Code: 61764	County: LIVINGSTON	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	SAINT JAMES HOSPITAL	140161	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST JAMES HOSPITAL SWING	14U161	16974		10/10/2002	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									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)	1		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	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	800	129	0	0	80	23	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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/19/2016 2:53 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/19/2016 2:53 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/19/2016 2:53 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/19/2016 2:53 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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.					109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	1	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.	Y	Y	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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/19/2016 2:53 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	149006	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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 06101	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/03/2014	12/31/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140161	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/19/2016 2:53 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/19/2016 2:53 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/15/2016	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	12/23/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/19/2016 2:53 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LOUIS	RAPTOPOULOS			41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(309)-624-9230	LOUIS.C.RAPTOPOULO@OSFHEALTHCARE.ORG			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/19/2016 2:53 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	12/23/2015			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)	12/23/2015			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.		GOVT REIMBURSEMENT SENIOR ANALYST		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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/19/2016 2:53 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	37	13,505	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		37	13,505	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	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)		42	15,330	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						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)		42				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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/19/2016 2:53 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,469	530	2,662			1.00
2.00	HMO and other (see instructions)	440	209				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	353	0	660			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,822	530	3,322			7.00
8.00	INTENSIVE CARE UNIT	486	190	919			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		80	387			13.00
14.00	Total (see instructions)	2,308	800	4,628	0.00	309.71	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	309.71	27.00
28.00	Observation Bed Days		125	1,109			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	23	31			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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/19/2016 2:53 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	632	262	1,410	1.00
2.00	HMO and other (see instructions)			136	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	632	262	1,410	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/19/2016 2:53 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	24,759,869	-21,355	24,738,514	640,878.00	38.60	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		9,518,691	1,178	9,519,869	96,205.00	98.95	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		13,338	0	13,338	202.00	66.03	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		723,506	0	723,506	5,230.00	138.34	13.00
14.00	Home office salaries & wage-related costs		5,376,622	0	5,376,622	98,996.00	54.31	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)		5,043,949	0	5,043,949			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,792,950	0	1,792,950			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	31,693	-23	31,670	12.00	2,639.17	26.00
27.00	Administrative & General	5.00	2,117,991	-1,899	2,116,092	43,523.00	48.62	27.00
28.00	Administrative & General under contract (see inst.)		10,220	0	10,220	52.00	196.54	28.00
29.00	Maintenance & Repairs	6.00	57,581	-41	57,540	2,068.00	27.82	29.00
30.00	Operation of Plant	7.00	399,177	-284	398,893	16,590.00	24.04	30.00
31.00	Laundry & Linen Service	8.00	21,541	-15	21,526	2,017.00	10.67	31.00
32.00	Housekeeping	9.00	497,811	-5,042	492,769	39,430.00	12.50	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	403,205	-322,455	80,750	5,326.00	15.16	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	322,168	322,168	21,250.00	15.16	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	992,867	-213,005	779,862	20,913.00	37.29	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/19/2016 2:53 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	343,185	-244	342,941	15,083.00	22.74	41.00
42.00	Social Service	17.00	44,740	-345	44,395	1,903.00	23.33	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 2/19/2016 2:53 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		24,770,089	-21,355	24,748,734	640,930.00	38.61	1.00
2.00	Excluded area salaries (see instructions)		9,518,691	1,178	9,519,869	96,205.00	98.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)		15,251,398	-22,533	15,228,865	544,725.00	27.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		6,113,466	0	6,113,466	104,428.00	58.54	4.00
5.00	Subtotal wage-related costs (see inst.)		5,043,949	0	5,043,949	0.00	33.12	5.00
6.00	Total (sum of lines 3 thru 5)		26,408,813	-22,533	26,386,280	649,153.00	40.65	6.00
7.00	Total overhead cost (see instructions)		4,920,011	-221,185	4,698,826	168,167.00	27.94	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 2/19/2016 2:53 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,542,571	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)	312,352	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)	3,465,106	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)	0	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)	16,151	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	82,853	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,411,448	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-26,629	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	33,047	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,836,899	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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 2/19/2016 2:53 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/19/2016 2:53 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	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.	Y	10/10/2002	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	7	7	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	35	35	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	73	73	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	27	27	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	39	39	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	1	1	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	45	45	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	88	88	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	11	11	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	6	6	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/19/2016 2:53 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	7	7	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	2	2	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	5	5	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	7	7	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	353	353	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).	16974	16974	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	0	0.00		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)	0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/19/2016 2:53 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.186653	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,651,174	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	36,208,219	6.00
7.00	Medicaid cost (line 1 times line 6)	6,758,373	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)	1,107,199	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,107,199	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	1,523,135	3,242,545	4,765,680	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	284,298	605,231	889,529	21.00
22.00	Partial payment by patients approved for charity care	24,264	53,147	77,411	22.00
23.00	Cost of charity care (line 21 minus line 22)	260,034	552,084	812,118	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)	3,110,837	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	215,763	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,895,074	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	540,374	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,352,492	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,459,691	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,445,187	1,445,187	30,016	1,475,203	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,877,733	1,877,733	22,011	1,899,744	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	31,693	6,668,873	6,700,566	10,945	6,711,511	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,117,991	8,178,704	10,296,695	-53,926	10,242,769	5.00
6.00	00600	MAINTENANCE & REPAIRS	57,581	40,090	97,671	-41	97,630	6.00
7.00	00700	OPERATION OF PLANT	399,177	1,307,850	1,707,027	-284	1,706,743	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,541	123,942	145,483	-15	145,468	8.00
9.00	00900	HOUSEKEEPING	497,811	-9,009	488,802	-351	488,451	9.00
10.00	01000	DIETARY	403,205	156,085	559,290	-447,258	112,032	10.00
11.00	01100	CAFETERIA	0	0	0	446,971	446,971	11.00
13.00	01300	NURSING ADMINISTRATION	992,867	244,542	1,237,409	-223,637	1,013,772	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	343,185	27,770	370,955	-244	370,711	16.00
17.00	01700	SOCIAL SERVICE	44,740	705	45,445	-32	45,413	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,097,756	173,974	2,271,730	-2,179	2,269,551	30.00
31.00	03100	INTENSIVE CARE UNIT	746,014	155,438	901,452	-627	900,825	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,615,987	2,250,759	3,866,746	-1,625,332	2,241,414	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	655,081	655,081	-44,610	610,471	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429,896	81,960	511,856	-306	511,550	54.00
54.10	03630	ULTRA SOUND	186,025	43,598	229,623	-132	229,491	54.10
54.20	03440	MAMMOGRAPHY	139,442	141,739	281,181	-99	281,082	54.20
56.00	05600	RADIOISOTOPE	73,215	175,793	249,008	-52	248,956	56.00
57.00	05700	CT SCAN	142,778	504,843	647,621	-568	647,053	57.00
58.00	05800	MRI	157,035	280,326	437,361	-222	437,139	58.00
60.00	06000	LABORATORY	892,825	1,085,874	1,978,699	-136,262	1,842,437	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	135,627	135,627	63.00
65.00	06500	RESPIRATORY THERAPY	303,597	51,324	354,921	-239	354,682	65.00
66.00	06600	PHYSICAL THERAPY	617,055	6,788	623,843	123,284	747,127	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,486	-323	200,163	36,052	236,215	67.00
68.00	06800	SPEECH PATHOLOGY	190,332	109,738	300,070	59,375	359,445	68.00
69.00	06900	ELECTROCARDIOLOGY	194,559	40,480	235,039	-138	234,901	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	178,040	92,353	270,393	-127	270,266	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	129,802	165,017	294,819	620,613	915,432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,032,368	1,032,368	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	538,477	1,379,467	1,917,944	57,633	1,975,577	73.00
76.00	03950	DIABETES SERVICES	61,691	1,697	63,388	-44	63,344	76.00
76.97	07697	CARDIAC REHABILITATION	57,629	2,372	60,001	-995	59,006	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,378,746	1,827,766	3,206,512	-38,391	3,168,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,241,178	29,288,536	44,529,714	-1,216	44,528,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,565	9,579	28,144	-13	28,131	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,346,353	13,327,971	22,674,324	385	22,674,709	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	954	954	192.01
192.02	19202	FUND DEVELOPMENT	143,051	338,186	481,237	-102	481,135	192.02
192.03	19203	PULMONARY FUNCTION	10,722	123	10,845	-8	10,837	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	24,759,869	42,964,395	67,724,264	0	67,724,264	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	201,038	1,676,241		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	136,560	2,036,304		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-137,082	6,574,429		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,553,364	8,689,405		5.00
6.00	00600	MAINTENANCE & REPAIRS	-136	97,494		6.00
7.00	00700	OPERATION OF PLANT	-19,598	1,687,145		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	145,468		8.00
9.00	00900	HOUSEKEEPING	0	488,451		9.00
10.00	01000	DIETARY	-17,134	94,898		10.00
11.00	01100	CAFETERIA	-140,992	305,979		11.00
13.00	01300	NURSING ADMINISTRATION	-23,099	990,673		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,868	345,843		16.00
17.00	01700	SOCIAL SERVICE	0	45,413		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-8,692	2,260,859		30.00
31.00	03100	INTENSIVE CARE UNIT	0	900,825		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,241,414		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	-361,209	249,262		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20,983	490,567		54.00
54.10	03630	ULTRA SOUND	0	229,491		54.10
54.20	03440	MAMMOGRAPHY	0	281,082		54.20
56.00	05600	RADIOISOTOPE	-4,159	244,797		56.00
57.00	05700	CT SCAN	-54,109	592,944		57.00
58.00	05800	MRI	-11,846	425,293		58.00
60.00	06000	LABORATORY	-12,543	1,829,894		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	135,627		63.00
65.00	06500	RESPIRATORY THERAPY	0	354,682		65.00
66.00	06600	PHYSICAL THERAPY	-460	746,667		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	236,215		67.00
68.00	06800	SPEECH PATHOLOGY	-618	358,827		68.00
69.00	06900	ELECTROCARDIOLOGY	0	234,901		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-9,712	260,554		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-13,005	902,427		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,032,368		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-659,845	1,315,732		73.00
76.00	03950	DIABETES SERVICES	-525	62,819		76.00
76.97	07697	CARDIAC REHABILITATION	-12,584	46,422		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,642,626	1,525,495		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,391,591	40,136,907		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,131		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	22,674,709		192.00
192.01	19201	CARDIAC PHASE III	0	954		192.01
192.02	19202	FUND DEVELOPMENT	0	481,135		192.02
192.03	19203	PULMONARY FUNCTION	0	10,837		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,391,591	63,332,673		200.00

RECLASSIFICATIONS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/19/2016 2:53 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - FIRE INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	52,027	1.00
	0		0	52,027	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	322,397	124,803	1.00
	0		322,397	124,803	
	D - BLOOD				
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	135,627	1.00
	0		0	135,627	
	E - REHAB ADMIN RECLASS				
1.00	PHYSICAL THERAPY	66.00	117,906	5,901	1.00
2.00	OCCUPATIONAL THERAPY	67.00	37,831	1,893	2.00
3.00	SPEECH PATHOLOGY	68.00	56,713	2,838	3.00
	0		212,450	10,632	
	F - CARDIAC PHASE III NON-ALLOW				
1.00	CARDIAC PHASE III	192.01	916	38	1.00
	0		916	38	
	G - IMPLANT DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,032,368	1.00
	0		0	1,032,368	
	H - MED SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	620,705	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	620,705	
	I - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	58,016	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	58,016	
	J - DISABILITY				
1.00		0.00	0	0	1.00
2.00	HOUSEKEEPING	9.00	0	4,691	2.00
3.00	SOCIAL SERVICE	17.00	0	313	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	27	4.00
5.00	OPERATING ROOM	50.00	0	4,818	5.00
6.00	LABORATORY	60.00	0	538	6.00
	0		0	10,387	
	K - OSFMG CONTRACT SALARY				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	385	0	1.00
	0		385	0	
	Z - VACATION ACCRUAL RECLASS				
1.00		0.00	0	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00

RECLASSIFICATIONS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/19/2016 2:53 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,968	37.00
	0		0	10,968	
500.00	Grand Total: Increases		536,148	2,055,571	500.00

RECLASSIFICATIONS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/19/2016 2:53 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - FIRE INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,027	12		1.00
	0		0	52,027			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	322,397	124,803	0		1.00
	0		322,397	124,803			
	D - BLOOD						
1.00	LABORATORY	60.00	0	135,627	0		1.00
	0		0	135,627			
	E - REHAB ADMIN RECLASS						
1.00	NURSING ADMINISTRATION	13.00	212,450	10,632	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		212,450	10,632			
	F - CARDIAC PHASE III NON-ALLOW						
1.00	CARDIAC REHABILITATION	76.97	916	38	0		1.00
	0		916	38			
	G - IMPLANT DEVICE						
1.00	OPERATING ROOM	50.00	0	1,032,368	0		1.00
	0		0	1,032,368			
	H - MED SUPPLIES CHARGED TO PATIENTS						
1.00	OPERATING ROOM	50.00	0	586,811	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	30,369	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	23	0		3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	3,502	0		4.00
	TOTALS		0	620,705			
	I - DRUGS CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	686	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	96	0		2.00
3.00	OPERATING ROOM	50.00	0	5,007	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	14,241	0		4.00
5.00	CT SCAN	57.00	0	466	0		5.00
6.00	MRI	58.00	0	110	0		6.00
7.00	EMERGENCY	91.00	0	37,410	0		7.00
	TOTALS		0	58,016			
	J - DISABILITY						
1.00		0.00	0	0	0		1.00
2.00	HOUSEKEEPING	9.00	4,691	0	0		2.00
3.00	SOCIAL SERVICE	17.00	313	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	27	0	0		4.00
5.00	OPERATING ROOM	50.00	4,818	0	0		5.00
6.00	LABORATORY	60.00	538	0	0		6.00
	0		10,387	0			
	K - OSFMG CONTRACT SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	385	0	0		1.00
	0		385	0			
	Z - VACATION ACCRUAL RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,514	0	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	41	0	0		2.00
3.00	OPERATION OF PLANT	7.00	284	0	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	15	0	0		4.00
5.00	HOUSEKEEPING	9.00	351	0	0		5.00
6.00	DIETARY	10.00	58	0	0		6.00
7.00	NURSING ADMINISTRATION	13.00	555	0	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	244	0	0		8.00
9.00	SOCIAL SERVICE	17.00	32	0	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	1,493	0	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	531	0	0		11.00
12.00	OPERATING ROOM	50.00	1,146	0	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	306	0	0		13.00
14.00	ULTRA SOUND	54.10	132	0	0		14.00
15.00	MAMMOGRAPHY	54.20	99	0	0		15.00
16.00	RADIOISOTOPE	56.00	52	0	0		16.00
17.00	CT SCAN	57.00	102	0	0		17.00
18.00	MRI	58.00	112	0	0		18.00
19.00	LABORATORY	60.00	635	0	0		19.00
20.00	RESPIRATORY THERAPY	65.00	216	0	0		20.00
21.00	PHYSICAL THERAPY	66.00	523	0	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	170	0	0		22.00
23.00	SPEECH PATHOLOGY	68.00	176	0	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	138	0	0		24.00
25.00	CARDIAC REHABILITATION	76.97	1	0	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	127	0	0		26.00

RECLASSIFICATIONS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/19/2016 2:53 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
27.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	92	0	0		27.00
28.00	DRUGS CHARGED TO PATIENTS	73.00	383	0	0		28.00
29.00	DIABETES SERVICES	76.00	44	0	0		29.00
30.00	CARDIAC REHABILITATION	76.97	40	0	0		30.00
31.00	EMERGENCY	91.00	981	0	0		31.00
32.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	13	0	0		32.00
33.00	FUND DEVELOPMENT	192.02	102	0	0		33.00
34.00	PULMONARY FUNCTION	192.03	8	0	0		34.00
35.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	23	0	0		35.00
36.00	CAFETERIA	11.00	229	0	0		36.00
37.00		0.00	0	0	0		37.00
	0		10,968	0			
500.00	Grand Total: Decreases		557,503	2,034,216			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/19/2016 2:53 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	749,404	0	0	0	149,391	1.00
2.00	Land Improvements	2,287,903	0	0	0	0	2.00
3.00	Buildings and Fixtures	36,829,113	1,202,065	0	1,202,065	24,645	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	23,395,784	4,421,524	0	4,421,524	42,274	5.00
6.00	Movable Equipment	97,230	0	0	0	1,190	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	63,359,434	5,623,589	0	5,623,589	217,500	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	63,359,434	5,623,589	0	5,623,589	217,500	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	600,013	0	1.00
2.00	Land Improvements	2,287,903	0	2.00
3.00	Buildings and Fixtures	38,006,533	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	27,775,034	0	5.00
6.00	Movable Equipment	96,040	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,765,523	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	68,765,523	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/19/2016 2:53 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,445,187	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,877,733	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,322,920	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,445,187		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,877,733		2.00
3.00	Total (sum of lines 1-2)	0	3,322,920		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/19/2016 2:53 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	38,006,533	0	38,006,533	0.576926	30,016	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	27,871,074	0	27,871,074	0.423074	22,011	2.00
3.00	Total (sum of lines 1-2)	65,877,607	0	65,877,607	1.000000	52,027	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	30,016	1,646,225	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	22,011	2,014,293	0	2.00
3.00	Total (sum of lines 1-2)	0	0	52,027	3,660,518	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	0	30,016	0	0	1,676,241	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	22,011	0	0	2,036,304	2.00
3.00	Total (sum of lines 1-2)	0	52,027	0	0	3,712,545	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/19/2016 2:53 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,546	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,085,935			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	275,326			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-140,992	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	B	-2,623	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-24,868	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	-10,861	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-27,615	ADMINISTRATIVE & GENERAL	5.00	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUITMENT	A	-400	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/19/2016 2:53 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	LOBBYING DUES INCLUDING AHA AND IHA	A	-23,624	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	UNEMPLOYMENT COMPENSATION	A	26,629	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	PRE EMPLOYMENT PHYSICALS	A	-30,720	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
37.00	PRENATAL BABY PICTURES	B	-175	ADULTS & PEDIATRICS	30.00	0	37.00
38.00	EMERGENCY MEDICAL TRANSPORTATIO	B	-9,330	EMERGENCY	91.00	0	38.00
39.00	LAB NON PATIENT INCOME	B	-1,115	LABORATORY	60.00	0	39.00
39.01	CARDIAC REHAB	B	-6,584	CARDIAC REHABILITATION	76.97	0	39.01
40.00	RADIOLOGY - SILVER RECOVERY & F	B	-151	RADIOLOGY-DIAGNOSTIC	54.00	0	40.00
41.00	PEDIATRIC DEVELOPMENT	B	-460	PHYSICAL THERAPY	66.00	0	41.00
42.00	AUDIOLOGY	B	-618	SPEECH PATHOLOGY	68.00	0	42.00
43.00	EMPLOYEE BENEFIT OFFSET - GEN & ADMI	A	-3,741	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.00
44.00	EMPLOYEE BENEFIT OFFSET - ADULTS & P	A	-1,023	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00	HOSPITAL ADMIN - FARM INCOME &	B	-44,816	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	REYNOLDS STREET PROPERTY - RENT	B	-17,682	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	CHAPLAINCY - CANDLES & RENTAL I	B	-10,650	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00	INSERVICE EDUC - NURSING - CLAS	B	-265	NURSING ADMINISTRATION	13.00	0	48.00
49.00	EMPLOYEE BENEFIT OFFSET - CARDIAC RE	A	-1,021	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.00
49.01	DIABETES SERVICES	B	-525	DIABETES SERVICES	76.00	0	49.01
49.03	GENERAL ACCOUNTING	B	-7,344	ADMINISTRATIVE & GENERAL	5.00	0	49.03
49.04	REHAB ADMIN	B	-20	NURSING ADMINISTRATION	13.00	0	49.04
49.11	DIETARY O/P REVENUE	B	-6,273	DIETARY	10.00	0	49.11
49.12	MEDICAID ASSESSMENT	A	-1,572,912	ADMINISTRATIVE & GENERAL	5.00	0	49.12
49.13	REVENUE CYCLE ADMINISTRATION	B	-150	ADMINISTRATIVE & GENERAL	5.00	0	49.13
49.15	340B PHARMACY	A	-657,222	DRUGS CHARGED TO PATIENTS	73.00	0	49.15
49.16	MARKETING AND ADVERTISING	A	-1,285	ADMINISTRATIVE & GENERAL	5.00	0	49.16
49.17			0		0.00	0	49.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,391,591				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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/19/2016 2:53 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CORP OFF CHARGE - BUILDING	201,038	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CORP OFF CHARGE - EQUIP	918,374	781,814	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CORP OFF CHARGE - EB	833,623	960,829	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OFFICE CHARGES - A	5,082,319	5,857,849	3.01
3.02	7.00	OPERATION OF PLANT	CORPORATE OFFICE CHARGES - P	128,433	148,031	3.02
4.00	13.00	NURSING ADMINISTRATION	CORPORATE OFFICE CHARGES - N	149,510	172,324	4.00
4.01	71.00	MEDICAL SUPPLIES CHARGED TO	CORPORATE OFFICE CHARGES - M	85,225	98,230	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OFFICE-INTEREST	986,963	0	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	SFI PURCHASED MAINT	16,292	26,653	4.03
4.04	56.00	RADIOISOTOPE	SFI PURCHASED MAINT	1,504	2,461	4.04
4.05	57.00	CT SCAN	SFI PURCHASED MAINT	14,653	23,972	4.05
4.06	58.00	MRI	SFI PURCHASED MAINT	18,629	30,475	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	SFI PURCHASED SERVICES	16,465	26,936	4.07
4.08	56.00	RADIOISOTOPE	SFI PURCHASED SERVICES	5,037	8,239	4.08
4.09	57.00	CT SCAN	SFI PURCHASED SERVICES	69,486	113,674	4.09
4.10	60.00	LABORATORY	SYSTEMS LAB	625,278	625,278	4.10
4.11	31.00	INTENSIVE CARE UNIT	EICU	120,388	120,388	4.11
4.12	6.00	MAINTENANCE & REPAIRS	SFI PURCHASED MAINT	92	150	4.12
4.13	6.00	MAINTENANCE & REPAIRS	SFI PURCHASES SERVICES	123	201	4.13
4.14	57.00	CT SCAN	PET SCAN	131,678	132,280	4.14
4.15	0.00			0	0	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,405,110	9,129,784	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	OSF HEALTHCARE SYSTEM	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/19/2016 2:53 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	201,038	9		1.00
2.00	136,560	9		2.00
3.00	-127,206	0		3.00
3.01	-775,530	0		3.01
3.02	-19,598	0		3.02
4.00	-22,814	0		4.00
4.01	-13,005	0		4.01
4.02	986,963	0		4.02
4.03	-10,361	0		4.03
4.04	-957	0		4.04
4.05	-9,319	0		4.05
4.06	-11,846	0		4.06
4.07	-10,471	0		4.07
4.08	-3,202	0		4.08
4.09	-44,188	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	-58	0		4.12
4.13	-78	0		4.13
4.14	-602	0		4.14
4.15	0	0		4.15
5.00	275,326			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/19/2016 2:53 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	212,500	0	212,500	159,800	2,040	1.00
2.00	30.00	ADULTS & PEDIATRICS	8,517	8,517	0	150,200	0	2.00
3.00	53.00	ANESTHESIOLOGY	603,923	123,989	479,934	167,500	3,014	3.00
4.00	60.00	LABORATORY	12,128	11,056	1,072	208,000	7	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	9,712	9,712	0	159,800	0	5.00
6.00	76.97	CARDIAC REHABILITATION	6,000	6,000	0	159,800	0	6.00
7.00	91.00	EMERGENCY	1,646,280	1,616,280	30,000	159,800	169	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			2,499,060	1,775,554	723,506		5,230	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	5.00	ADMINISTRATIVE & GENERAL	156,727	7,836	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	242,714	12,136	0	0	0	3.00
4.00	60.00	LABORATORY	700	35	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	12,984	649	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			413,125	20,656	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	5.00	ADMINISTRATIVE & GENERAL	0	156,727	55,773	55,773		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	8,517		2.00
3.00	53.00	ANESTHESIOLOGY	0	242,714	237,220	361,209		3.00
4.00	60.00	LABORATORY	0	700	372	11,428		4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	9,712		5.00
6.00	76.97	CARDIAC REHABILITATION	0	0	0	6,000		6.00
7.00	91.00	EMERGENCY	0	12,984	17,016	1,633,296		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	413,125	310,381	2,085,935		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,676,241	1,676,241				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,036,304		2,036,304			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,574,429	0	582	6,575,011		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,689,405	572,552	1,263,255	563,412	11,088,624	5.00
6.00	00600	MAINTENANCE & REPAIRS	97,494	13,984	3,006	15,320	129,804	6.00
7.00	00700	OPERATION OF PLANT	1,687,145	111,246	91,930	106,206	1,996,527	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	145,468	34,031	0	5,731	185,230	8.00
9.00	00900	HOUSEKEEPING	488,451	33,161	11,088	131,200	663,900	9.00
10.00	01000	DIETARY	94,898	10,504	679	21,500	127,581	10.00
11.00	01100	CAFETERIA	305,979	41,899	2,709	85,778	436,365	11.00
13.00	01300	NURSING ADMINISTRATION	990,673	3,778	44,743	207,639	1,246,833	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	345,843	28,383	0	91,308	465,534	16.00
17.00	01700	SOCIAL SERVICE	45,413	6,843	0	11,820	64,076	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,260,859	205,601	73,529	556,523	3,096,512	30.00
31.00	03100	INTENSIVE CARE UNIT	900,825	36,498	35,267	198,486	1,171,076	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,241,414	188,423	254,410	428,670	3,112,917	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	249,262	0	13,447	0	262,709	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	490,567	70,529	60,339	114,379	735,814	54.00
54.10	03630	ULTRA SOUND	229,491	3,739	7,873	49,494	290,597	54.10
54.20	03440	MAMMOGRAPHY	281,082	0	0	37,100	318,182	54.20
56.00	05600	RADIOISOTOPE	244,797	636	0	19,480	264,913	56.00
57.00	05700	CT SCAN	592,944	8,453	49,302	37,988	688,687	57.00
58.00	05800	MRI	425,293	0	11,408	41,781	478,482	58.00
60.00	06000	LABORATORY	1,829,894	1,935	20,268	237,403	2,089,500	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	135,627	0	0	0	135,627	63.00
65.00	06500	RESPIRATORY THERAPY	354,682	5,427	3,605	80,775	444,489	65.00
66.00	06600	PHYSICAL THERAPY	746,667	57,532	17,993	195,545	1,017,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	236,215	17,788	1,992	63,407	319,402	67.00
68.00	06800	SPEECH PATHOLOGY	358,827	26,656	15,150	65,729	466,362	68.00
69.00	06900	ELECTROCARDIOLOGY	234,901	3,012	5,275	51,765	294,953	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	260,554	0	10,590	47,370	318,514	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	902,427	24,838	2,412	34,535	964,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,032,368	0	0	0	1,032,368	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,315,732	13,218	4,250	143,268	1,476,468	73.00
76.00	03950	DIABETES SERVICES	62,819	1,337	0	16,414	80,570	76.00
76.97	07697	CARDIAC REHABILITATION	46,422	17,139	8,993	13,492	86,046	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,525,495	69,568	19,721	366,831	1,981,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,136,907	1,608,710	2,033,816	4,040,349	37,532,226	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,131	6,843	0	4,939	39,913	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,674,709	0	2,488	2,488,566	25,165,763	192.00
192.01	19201	CARDIAC PHASE III	954	273	0	244	1,471	192.01
192.02	19202	FUND DEVELOPMENT	481,135	27,812	0	38,060	547,007	192.02
192.03	19203	PULMONARY FUNCTION	10,837	0	0	2,853	13,690	192.03
193.00	19300	NONPAID WORKERS	0	32,603	0	0	32,603	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	63,332,673	1,676,241	2,036,304	6,575,011	63,332,673	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,088,624					5.00
6.00	00600	MAINTENANCE & REPAIRS	27,551	157,355				6.00
7.00	00700	OPERATION OF PLANT	423,757	12,254	2,432,538			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,315	3,749	62,844	291,138		8.00
9.00	00900	HOUSEKEEPING	140,911	3,653	61,237	0	869,701	9.00
10.00	01000	DIETARY	27,079	1,157	19,397	628	7,308	10.00
11.00	01100	CAFETERIA	92,617	4,615	77,374	2,505	29,150	11.00
13.00	01300	NURSING ADMINISTRATION	264,637	416	6,977	0	2,629	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,808	3,126	52,414	0	19,747	16.00
17.00	01700	SOCIAL SERVICE	13,600	754	12,636	0	4,761	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	657,225	22,648	379,676	92,723	143,041	30.00
31.00	03100	INTENSIVE CARE UNIT	248,557	4,020	67,399	17,963	25,392	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	660,707	20,755	347,954	64,751	131,090	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	55,759	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,174	7,769	130,243	31,720	49,068	54.00
54.10	03630	ULTRA SOUND	61,678	412	6,905	0	2,602	54.10
54.20	03440	MAMMOGRAPHY	67,533	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	56,227	70	1,175	0	443	56.00
57.00	05700	CT SCAN	146,172	931	15,609	0	5,881	57.00
58.00	05800	MRI	101,556	0	0	0	0	58.00
60.00	06000	LABORATORY	443,490	213	3,573	0	1,346	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	28,786	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	94,341	598	10,022	0	3,776	65.00
66.00	06600	PHYSICAL THERAPY	216,012	6,337	106,242	10,721	40,026	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,792	1,959	32,848	0	12,376	67.00
68.00	06800	SPEECH PATHOLOGY	98,984	2,936	49,225	0	18,545	68.00
69.00	06900	ELECTROCARDIOLOGY	62,603	332	5,563	0	2,096	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	67,604	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	204,651	2,736	45,868	0	17,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,117	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	313,376	1,456	24,409	0	9,196	73.00
76.00	03950	DIABETES SERVICES	17,101	147	2,470	0	930	76.00
76.97	07697	CARDIAC REHABILITATION	18,263	1,888	31,650	0	11,924	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	420,592	7,663	128,469	67,724	48,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,612,575	112,594	1,682,179	288,735	587,008	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,471	754	12,636	0	4,761	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,341,339	37,322	625,654	2,403	235,711	192.00
192.01	19201	CARDIAC PHASE III	312	30	504	0	190	192.01
192.02	19202	FUND DEVELOPMENT	116,101	3,064	51,359	0	19,349	192.02
192.03	19203	PULMONARY FUNCTION	2,906	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	6,920	3,591	60,206	0	22,682	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,088,624	157,355	2,432,538	291,138	869,701	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	183,150					10.00
11.00	01100	CAFETERIA	0	642,626				11.00
13.00	01300	NURSING ADMINISTRATION	0	26,129	1,547,621			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,936	0	658,565		16.00
17.00	01700	SOCIAL SERVICE	0	2,380	0	0	98,207	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	145,084	101,036	590,057	33,239	77,081	30.00
31.00	03100	INTENSIVE CARE UNIT	30,696	28,823	168,326	10,932	21,126	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,370	72,528	423,564	69,475	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	9,896	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,616	0	25,504	0	54.00
54.10	03630	ULTRA SOUND	0	7,297	0	15,993	0	54.10
54.20	03440	MAMMOGRAPHY	0	6,513	0	9,074	0	54.20
56.00	05600	RADIOISOTOPE	0	2,851	0	13,688	0	56.00
57.00	05700	CT SCAN	0	6,251	0	71,145	0	57.00
58.00	05800	MRI	0	6,905	0	36,415	0	58.00
60.00	06000	LABORATORY	0	50,950	0	132,240	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,159	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	14,830	0	5,993	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,569	0	15,288	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,834	0	7,426	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,887	0	3,619	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,180	0	23,016	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,919	0	8,970	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,076	0	34,604	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,897	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,228	0	51,250	0	73.00
76.00	03950	DIABETES SERVICES	0	2,799	16,344	459	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,909	0	1,626	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	59,816	349,330	49,657	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	183,150	522,262	1,547,621	658,565	98,207	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	602	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	114,401	0	0	0	192.00
192.01	19201	CARDIAC PHASE III	0	26	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	4,917	0	0	0	192.02
192.03	19203	PULMONARY FUNCTION	0	418	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	183,150	642,626	1,547,621	658,565	98,207	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,338,322	0	5,338,322		30.00
31.00	03100	INTENSIVE CARE UNIT	1,794,310	0	1,794,310		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,911,111	0	4,911,111		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	328,364	0	328,364		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,155,908	0	1,155,908		54.00
54.10	03630	ULTRA SOUND	385,484	0	385,484		54.10
54.20	03440	MAMMOGRAPHY	401,302	0	401,302		54.20
56.00	05600	RADIOISOTOPE	339,367	0	339,367		56.00
57.00	05700	CT SCAN	934,676	0	934,676		57.00
58.00	05800	MRI	623,358	0	623,358		58.00
60.00	06000	LABORATORY	2,721,312	0	2,721,312		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	166,572	0	166,572		63.00
65.00	06500	RESPIRATORY THERAPY	574,049	0	574,049		65.00
66.00	06600	PHYSICAL THERAPY	1,443,932	0	1,443,932		66.00
67.00	06700	OCCUPATIONAL THERAPY	451,637	0	451,637		67.00
68.00	06800	SPEECH PATHOLOGY	649,558	0	649,558		68.00
69.00	06900	ELECTROCARDIOLOGY	397,743	0	397,743		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	404,007	0	404,007		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,278,428	0	1,278,428		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,278,382	0	1,278,382		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,890,383	0	1,890,383		73.00
76.00	03950	DIABETES SERVICES	120,820	0	120,820		76.00
76.97	07697	CARDIAC REHABILITATION	153,306	0	153,306		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,113,266	0	3,113,266		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,855,597	0	30,855,597		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	67,137	0	67,137		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,522,593	0	31,522,593		192.00
192.01	19201	CARDIAC PHASE III	2,533	0	2,533		192.01
192.02	19202	FUND DEVELOPMENT	741,797	0	741,797		192.02
192.03	19203	PULMONARY FUNCTION	17,014	0	17,014		192.03
193.00	19300	NONPAID WORKERS	126,002	0	126,002		193.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	63,332,673	0	63,332,673		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/19/2016 2:53 pm

		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	0	582	582	582	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	113,184	572,552	1,263,255	1,948,991	51	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	13,984	3,006	16,990	1	6.00
7.00	00700	OPERATION OF PLANT	32	111,246	91,930	203,208	10	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,031	0	34,031	1	8.00
9.00	00900	HOUSEKEEPING	82	33,161	11,088	44,331	12	9.00
10.00	01000	DIETARY	214	10,504	679	11,397	2	10.00
11.00	01100	CAFETERIA	0	41,899	2,709	44,608	8	11.00
13.00	01300	NURSING ADMINISTRATION	1,610	3,778	44,743	50,131	19	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,077	28,383	0	30,460	8	16.00
17.00	01700	SOCIAL SERVICE	70	6,843	0	6,913	1	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,450	205,601	73,529	282,580	50	30.00
31.00	03100	INTENSIVE CARE UNIT	508	36,498	35,267	72,273	18	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,035	188,423	254,410	487,868	39	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	13,447	13,447	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	591	70,529	60,339	131,459	10	54.00
54.10	03630	ULTRA SOUND	0	3,739	7,873	11,612	4	54.10
54.20	03440	MAMMOGRAPHY	77,279	0	0	77,279	3	54.20
56.00	05600	RADIOISOTOPE	0	636	0	636	2	56.00
57.00	05700	CT SCAN	184,438	8,453	49,302	242,193	3	57.00
58.00	05800	MRI	257,218	0	11,408	268,626	4	58.00
60.00	06000	LABORATORY	85,108	1,935	20,268	107,311	21	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,787	5,427	3,605	12,819	7	65.00
66.00	06600	PHYSICAL THERAPY	1,750	57,532	17,993	77,275	18	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,788	1,992	19,780	6	67.00
68.00	06800	SPEECH PATHOLOGY	0	26,656	15,150	41,806	6	68.00
69.00	06900	ELECTROCARDIOLOGY	72	3,012	5,275	8,359	5	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61,657	0	10,590	72,247	4	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	897	24,838	2,412	28,147	3	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,193	13,218	4,250	34,661	13	73.00
76.00	03950	DIABETES SERVICES	138	1,337	0	1,475	1	76.00
76.97	07697	CARDIAC REHABILITATION	0	17,139	8,993	26,132	1	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,197	69,568	19,721	93,486	33	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	860,587	1,608,710	2,033,816	4,503,113	364	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	133	6,843	0	6,976	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	553,687	0	2,488	556,175	215	192.00
192.01	19201	CARDIAC PHASE III	0	273	0	273	0	192.01
192.02	19202	FUND DEVELOPMENT	637	27,812	0	28,449	3	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	32,603	0	32,603	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,415,044	1,676,241	2,036,304	5,127,589	582	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,949,042					5.00
6.00	00600	MAINTENANCE & REPAIRS	4,842	21,833				6.00
7.00	00700	OPERATION OF PLANT	74,482	1,700	279,400			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,910	520	7,218	48,680		8.00
9.00	00900	HOUSEKEEPING	24,767	507	7,034	0	76,651	9.00
10.00	01000	DIETARY	4,760	161	2,228	105	644	10.00
11.00	01100	CAFETERIA	16,279	640	8,887	419	2,569	11.00
13.00	01300	NURSING ADMINISTRATION	46,514	58	801	0	232	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,367	434	6,020	0	1,740	16.00
17.00	01700	SOCIAL SERVICE	2,390	105	1,451	0	420	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	115,518	3,142	43,609	15,503	12,607	30.00
31.00	03100	INTENSIVE CARE UNIT	43,688	558	7,741	3,003	2,238	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	116,130	2,880	39,966	10,827	11,554	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	9,801	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,450	1,078	14,960	5,304	4,325	54.00
54.10	03630	ULTRA SOUND	10,841	57	793	0	229	54.10
54.20	03440	MAMMOGRAPHY	11,870	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	9,883	10	135	0	39	56.00
57.00	05700	CT SCAN	25,692	129	1,793	0	518	57.00
58.00	05800	MRI	17,850	0	0	0	0	58.00
60.00	06000	LABORATORY	77,951	30	410	0	119	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,060	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	16,582	83	1,151	0	333	65.00
66.00	06600	PHYSICAL THERAPY	37,968	879	12,203	1,793	3,528	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,916	272	3,773	0	1,091	67.00
68.00	06800	SPEECH PATHOLOGY	17,398	407	5,654	0	1,634	68.00
69.00	06900	ELECTROCARDIOLOGY	11,004	46	639	0	185	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,882	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,971	380	5,268	0	1,523	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,514	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,081	202	2,804	0	810	73.00
76.00	03950	DIABETES SERVICES	3,006	20	284	0	82	76.00
76.97	07697	CARDIAC REHABILITATION	3,210	262	3,635	0	1,051	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	73,926	1,063	14,756	11,324	4,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	986,503	15,623	193,213	48,278	51,737	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	105	1,451	0	420	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	938,861	5,178	71,864	402	20,773	192.00
192.01	19201	CARDIAC PHASE III	55	4	58	0	17	192.01
192.02	19202	FUND DEVELOPMENT	20,407	425	5,899	0	1,705	192.02
192.03	19203	PULMONARY FUNCTION	511	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	1,216	498	6,915	0	1,999	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,949,042	21,833	279,400	48,680	76,651	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	19,297					10.00
11.00	01100	CAFETERIA	0	73,410				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,985	100,740			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,163	0	58,192		16.00
17.00	01700	SOCIAL SERVICE	0	272	0	0	11,552	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,287	11,542	38,409	2,937	9,067	30.00
31.00	03100	INTENSIVE CARE UNIT	3,234	3,293	10,957	966	2,485	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	776	8,285	27,571	6,138	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	874	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,241	0	2,253	0	54.00
54.10	03630	ULTRA SOUND	0	834	0	1,413	0	54.10
54.20	03440	MAMMOGRAPHY	0	744	0	802	0	54.20
56.00	05600	RADIOISOTOPE	0	326	0	1,209	0	56.00
57.00	05700	CT SCAN	0	714	0	6,286	0	57.00
58.00	05800	MRI	0	789	0	3,217	0	58.00
60.00	06000	LABORATORY	0	5,820	0	11,689	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	191	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,694	0	530	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,606	0	1,351	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,123	0	656	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,129	0	320	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,049	0	2,034	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,019	0	793	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,037	0	3,057	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,376	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,625	0	4,528	0	73.00
76.00	03950	DIABETES SERVICES	0	320	1,064	41	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	218	0	144	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	6,833	22,739	4,387	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,297	59,661	100,740	58,192	11,552	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	69	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,067	0	0	0	192.00
192.01	19201	CARDIAC PHASE III	0	3	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	562	0	0	0	192.02
192.03	19203	PULMONARY FUNCTION	0	48	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,297	73,410	100,740	58,192	11,552	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	550,251	0	550,251		30.00
31.00	03100	INTENSIVE CARE UNIT	150,454	0	150,454		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	712,034	0	712,034		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	24,122	0	24,122		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	189,080	0	189,080		54.00
54.10	03630	ULTRA SOUND	25,783	0	25,783		54.10
54.20	03440	MAMMOGRAPHY	90,698	0	90,698		54.20
56.00	05600	RADIOISOTOPE	12,240	0	12,240		56.00
57.00	05700	CT SCAN	277,328	0	277,328		57.00
58.00	05800	MRI	290,486	0	290,486		58.00
60.00	06000	LABORATORY	203,351	0	203,351		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,251	0	5,251		63.00
65.00	06500	RESPIRATORY THERAPY	33,199	0	33,199		65.00
66.00	06600	PHYSICAL THERAPY	138,621	0	138,621		66.00
67.00	06700	OCCUPATIONAL THERAPY	38,617	0	38,617		67.00
68.00	06800	SPEECH PATHOLOGY	68,354	0	68,354		68.00
69.00	06900	ELECTROCARDIOLOGY	23,321	0	23,321		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	85,945	0	85,945		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	75,386	0	75,386		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,890	0	40,890		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,724	0	99,724		73.00
76.00	03950	DIABETES SERVICES	6,293	0	6,293		76.00
76.97	07697	CARDIAC REHABILITATION	34,653	0	34,653		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	232,813	0	232,813		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,408,894	0	3,408,894		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,510	0	10,510		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,606,535	0	1,606,535		192.00
192.01	19201	CARDIAC PHASE III	410	0	410		192.01
192.02	19202	FUND DEVELOPMENT	57,450	0	57,450		192.02
192.03	19203	PULMONARY FUNCTION	559	0	559		192.03
193.00	19300	NONPAID WORKERS	43,231	0	43,231		193.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	5,127,589	0	5,127,589		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	129,101					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,877,733				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	537	24,694,827			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,097	1,164,882	2,116,092	-11,088,624	52,244,049	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,077	2,772	57,540	0	129,804	6.00
7.00	00700	OPERATION OF PLANT	8,568	84,771	398,893	0	1,996,527	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,621	0	21,526	0	185,230	8.00
9.00	00900	HOUSEKEEPING	2,554	10,225	492,769	0	663,900	9.00
10.00	01000	DIETARY	809	626	80,750	0	127,581	10.00
11.00	01100	CAFETERIA	3,227	2,498	322,168	0	436,365	11.00
13.00	01300	NURSING ADMINISTRATION	291	41,259	779,862	0	1,246,833	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,186	0	342,941	0	465,534	16.00
17.00	01700	SOCIAL SERVICE	527	0	44,395	0	64,076	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,835	67,803	2,090,218	0	3,096,512	30.00
31.00	03100	INTENSIVE CARE UNIT	2,811	32,521	745,483	0	1,171,076	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,512	234,599	1,610,023	0	3,112,917	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	12,400	0	0	262,709	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,432	55,640	429,590	0	735,814	54.00
54.10	03630	ULTRA SOUND	288	7,260	185,893	0	290,597	54.10
54.20	03440	MAMMOGRAPHY	0	0	139,343	0	318,182	54.20
56.00	05600	RADIOISOTOPE	49	0	73,163	0	264,913	56.00
57.00	05700	CT SCAN	651	45,463	142,676	0	688,687	57.00
58.00	05800	MRI	0	10,520	156,923	0	478,482	58.00
60.00	06000	LABORATORY	149	18,690	891,652	0	2,089,500	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	135,627	63.00
65.00	06500	RESPIRATORY THERAPY	418	3,324	303,381	0	444,489	65.00
66.00	06600	PHYSICAL THERAPY	4,431	16,592	734,438	0	1,017,737	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,370	1,837	238,147	0	319,402	67.00
68.00	06800	SPEECH PATHOLOGY	2,053	13,970	246,869	0	466,362	68.00
69.00	06900	ELECTROCARDIOLOGY	232	4,864	194,421	0	294,953	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,765	177,913	0	318,514	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,913	2,224	129,710	0	964,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,032,368	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,018	3,919	538,094	0	1,476,468	73.00
76.00	03950	DIABETES SERVICES	103	0	61,647	0	80,570	76.00
76.97	07697	CARDIAC REHABILITATION	1,320	8,293	50,673	0	86,046	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,358	18,185	1,377,765	0	1,981,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	123,900	1,875,439	15,174,958	-11,088,624	26,443,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	527	0	18,552	0	39,913	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,294	9,346,738	0	25,165,763	192.00
192.01	19201	CARDIAC PHASE III	21	0	916	0	1,471	192.01
192.02	19202	FUND DEVELOPMENT	2,142	0	142,949	0	547,007	192.02
192.03	19203	PULMONARY FUNCTION	0	0	10,714	0	13,690	192.03
193.00	19300	NONPAID WORKERS	2,511	0	0	0	32,603	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,676,241	2,036,304	6,575,011		11,088,624	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.983951	1.084448	0.266251		0.212247	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			582		1,949,042	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000024		0.037306	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	110,021					6.00
7.00	00700	OPERATION OF PLANT	8,568	101,453				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,621	2,621	238,792			8.00
9.00	00900	HOUSEKEEPING	2,554	2,554	0	96,278		9.00
10.00	01000	DIETARY	809	809	515	809	13,544	10.00
11.00	01100	CAFETERIA	3,227	3,227	2,055	3,227	0	11.00
13.00	01300	NURSING ADMINISTRATION	291	291	0	291	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,186	2,186	0	2,186	0	16.00
17.00	01700	SOCIAL SERVICE	527	527	0	527	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,835	15,835	76,052	15,835	10,729	30.00
31.00	03100	INTENSIVE CARE UNIT	2,811	2,811	14,733	2,811	2,270	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,512	14,512	53,109	14,512	545	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,432	5,432	26,017	5,432	0	54.00
54.10	03630	ULTRA SOUND	288	288	0	288	0	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	49	49	0	49	0	56.00
57.00	05700	CT SCAN	651	651	0	651	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	149	149	0	149	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	418	418	0	418	0	65.00
66.00	06600	PHYSICAL THERAPY	4,431	4,431	8,793	4,431	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,370	1,370	0	1,370	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,053	2,053	0	2,053	0	68.00
69.00	06900	ELECTROCARDIOLOGY	232	232	0	232	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,913	1,913	0	1,913	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,018	1,018	0	1,018	0	73.00
76.00	03950	DIABETES SERVICES	103	103	0	103	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,320	1,320	0	1,320	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,358	5,358	55,547	5,358	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	78,726	70,158	236,821	64,983	13,544	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	527	527	0	527	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,094	26,094	1,971	26,094	0	192.00
192.01	19201	CARDIAC PHASE III	21	21	0	21	0	192.01
192.02	19202	FUND DEVELOPMENT	2,142	2,142	0	2,142	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	2,511	2,511	0	2,511	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	157,355	2,432,538	291,138	869,701	183,150	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.430227	23.976994	1.219212	9.033227	13.522593	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,833	279,400	48,680	76,651	19,297	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.198444	2.753985	0.203859	0.796142	1.424764	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/19/2016 2:53 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	SOCIAL SERVICE (PATIENT DAYS)		
			11.00	13.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	24,570					11.00
13.00	01300	NURSING ADMINISTRATION	999	10,132				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	724	0	165,309,507			16.00
17.00	01700	SOCIAL SERVICE	91	0	0	4,272		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,863	3,863	8,343,135	3,353		30.00
31.00	03100	INTENSIVE CARE UNIT	1,102	1,102	2,744,060	919		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,773	2,773	17,438,573	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	2,483,860	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	750	0	6,401,542	0		54.00
54.10	03630	ULTRA SOUND	279	0	4,014,219	0		54.10
54.20	03440	MAMMOGRAPHY	249	0	2,277,609	0		54.20
56.00	05600	RADIOISOTOPE	109	0	3,435,721	0		56.00
57.00	05700	CT SCAN	239	0	17,857,601	0		57.00
58.00	05800	MRI	264	0	9,140,246	0		58.00
60.00	06000	LABORATORY	1,948	0	33,199,855	0		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	542,014	0		63.00
65.00	06500	RESPIRATORY THERAPY	567	0	1,504,280	0		65.00
66.00	06600	PHYSICAL THERAPY	1,207	0	3,837,470	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	376	0	1,863,895	0		67.00
68.00	06800	SPEECH PATHOLOGY	378	0	908,373	0		68.00
69.00	06900	ELECTROCARDIOLOGY	351	0	5,777,121	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	341	0	2,251,440	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	347	0	8,685,773	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,751,228	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	544	0	12,863,902	0		73.00
76.00	03950	DIABETES SERVICES	107	107	115,256	0		76.00
76.97	07697	CARDIAC REHABILITATION	73	0	408,186	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,287	2,287	12,464,148	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,968	10,132	165,309,507	4,272		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,374	0	0	0		192.00
192.01	19201	CARDIAC PHASE III	1	0	0	0		192.01
192.02	19202	FUND DEVELOPMENT	188	0	0	0		192.02
192.03	19203	PULMONARY FUNCTION	16	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	642,626	1,547,621	658,565	98,207		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.154904	152.745855	0.003984	22.988530		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	73,410	100,740	58,192	11,552		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.987790	9.942756	0.000352	2.704120		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,338,322		5,338,322	0	5,338,322	30.00
31.00	03100	INTENSIVE CARE UNIT	1,794,310		1,794,310	0	1,794,310	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,911,111		4,911,111	0	4,911,111	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	328,364		328,364	237,220	565,584	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,155,908		1,155,908	0	1,155,908	54.00
54.10	03630	ULTRA SOUND	385,484		385,484	0	385,484	54.10
54.20	03440	MAMMOGRAPHY	401,302		401,302	0	401,302	54.20
56.00	05600	RADIOISOTOPE	339,367		339,367	0	339,367	56.00
57.00	05700	CT SCAN	934,676		934,676	0	934,676	57.00
58.00	05800	MRI	623,358		623,358	0	623,358	58.00
60.00	06000	LABORATORY	2,721,312		2,721,312	372	2,721,684	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	166,572		166,572	0	166,572	63.00
65.00	06500	RESPIRATORY THERAPY	574,049	0	574,049	0	574,049	65.00
66.00	06600	PHYSICAL THERAPY	1,443,932	0	1,443,932	0	1,443,932	66.00
67.00	06700	OCCUPATIONAL THERAPY	451,637	0	451,637	0	451,637	67.00
68.00	06800	SPEECH PATHOLOGY	649,558	0	649,558	0	649,558	68.00
69.00	06900	ELECTROCARDIOLOGY	397,743		397,743	0	397,743	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	404,007		404,007	0	404,007	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,278,428		1,278,428	0	1,278,428	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,278,382		1,278,382	0	1,278,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,890,383		1,890,383	0	1,890,383	73.00
76.00	03950	DIABETES SERVICES	120,820		120,820	0	120,820	76.00
76.97	07697	CARDIAC REHABILITATION	153,306		153,306	0	153,306	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,113,266		3,113,266	17,016	3,130,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,569,934		1,569,934		1,569,934	92.00
200.00		Subtotal (see instructions)	32,425,531	0	32,425,531	254,608	32,680,139	200.00
201.00		Less Observation Beds	1,569,934		1,569,934		1,569,934	201.00
202.00		Total (see instructions)	30,855,597	0	30,855,597	254,608	31,110,205	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,749,527		6,749,527			30.00
31.00	03100	INTENSIVE CARE UNIT	2,542,914		2,542,914			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,448,067	13,025,448	17,473,515	0.281060	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	615,929	1,867,931	2,483,860	0.132199	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	599,518	5,820,166	6,419,684	0.180057	0.000000	54.00
54.10	03630	ULTRA SOUND	177,992	3,836,227	4,014,219	0.096030	0.000000	54.10
54.20	03440	MAMMOGRAPHY	0	2,277,609	2,277,609	0.176194	0.000000	54.20
56.00	05600	RADIOISOTOPE	180,026	3,255,695	3,435,721	0.098776	0.000000	56.00
57.00	05700	CT SCAN	1,930,992	17,071,896	19,002,888	0.049186	0.000000	57.00
58.00	05800	MRI	451,191	8,791,887	9,243,078	0.067441	0.000000	58.00
60.00	06000	LABORATORY	4,713,692	28,501,962	33,215,654	0.081929	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	157,497	384,517	542,014	0.307320	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	610,244	894,036	1,504,280	0.381610	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	563,649	3,273,821	3,837,470	0.376272	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	438,890	1,425,005	1,863,895	0.242308	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	71,134	837,239	908,373	0.715078	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	750,286	5,026,835	5,777,121	0.068848	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,997	2,240,443	2,251,440	0.179444	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,785,851	4,899,922	8,685,773	0.147186	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,888,211	1,863,017	6,751,228	0.189355	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,398,359	7,148,541	11,546,900	0.163713	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	115,256	115,256	1.048275	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	468	407,718	408,186	0.375579	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,478,204	10,985,944	12,464,148	0.249778	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	210,099	1,584,655	1,794,754	0.874735	0.000000	92.00
200.00		Subtotal (see instructions)	39,773,737	125,535,770	165,309,507			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,773,737	125,535,770	165,309,507			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.281060		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.227704		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180057		54.00
54.10	03630	ULTRA SOUND	0.096030		54.10
54.20	03440	MAMMOGRAPHY	0.176194		54.20
56.00	05600	RADIOISOTOPE	0.098776		56.00
57.00	05700	CT SCAN	0.049186		57.00
58.00	05800	MRI	0.067441		58.00
60.00	06000	LABORATORY	0.081940		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.307320		63.00
65.00	06500	RESPIRATORY THERAPY	0.381610		65.00
66.00	06600	PHYSICAL THERAPY	0.376272		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242308		67.00
68.00	06800	SPEECH PATHOLOGY	0.715078		68.00
69.00	06900	ELECTROCARDIOLOGY	0.068848		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179444		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.147186		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.189355		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163713		73.00
76.00	03950	DIABETES SERVICES	1.048275		76.00
76.97	07697	CARDIAC REHABILITATION	0.375579		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.251143		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.874735		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/19/2016 2:53 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,338,322		5,338,322	0	5,338,322	30.00
31.00	03100	INTENSIVE CARE UNIT	1,794,310		1,794,310	0	1,794,310	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,911,111		4,911,111	0	4,911,111	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	328,364		328,364	237,220	565,584	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,155,908		1,155,908	0	1,155,908	54.00
54.10	03630	ULTRA SOUND	385,484		385,484	0	385,484	54.10
54.20	03440	MAMMOGRAPHY	401,302		401,302	0	401,302	54.20
56.00	05600	RADIOISOTOPE	339,367		339,367	0	339,367	56.00
57.00	05700	CT SCAN	934,676		934,676	0	934,676	57.00
58.00	05800	MRI	623,358		623,358	0	623,358	58.00
60.00	06000	LABORATORY	2,721,312		2,721,312	372	2,721,684	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	166,572		166,572	0	166,572	63.00
65.00	06500	RESPIRATORY THERAPY	574,049	0	574,049	0	574,049	65.00
66.00	06600	PHYSICAL THERAPY	1,443,932	0	1,443,932	0	1,443,932	66.00
67.00	06700	OCCUPATIONAL THERAPY	451,637	0	451,637	0	451,637	67.00
68.00	06800	SPEECH PATHOLOGY	649,558	0	649,558	0	649,558	68.00
69.00	06900	ELECTROCARDIOLOGY	397,743		397,743	0	397,743	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	404,007		404,007	0	404,007	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,278,428		1,278,428	0	1,278,428	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,278,382		1,278,382	0	1,278,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,890,383		1,890,383	0	1,890,383	73.00
76.00	03950	DIABETES SERVICES	120,820		120,820	0	120,820	76.00
76.97	07697	CARDIAC REHABILITATION	153,306		153,306	0	153,306	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,113,266		3,113,266	17,016	3,130,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,569,934		1,569,934		1,569,934	92.00
200.00		Subtotal (see instructions)	32,425,531	0	32,425,531	254,608	32,680,139	200.00
201.00		Less Observation Beds	1,569,934		1,569,934		1,569,934	201.00
202.00		Total (see instructions)	30,855,597	0	30,855,597	254,608	31,110,205	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/19/2016 2:53 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,749,527		6,749,527			30.00
31.00	03100	INTENSIVE CARE UNIT	2,542,914		2,542,914			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,448,067	13,025,448	17,473,515	0.281060	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	615,929	1,867,931	2,483,860	0.132199	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	599,518	5,820,166	6,419,684	0.180057	0.000000	54.00
54.10	03630	ULTRA SOUND	177,992	3,836,227	4,014,219	0.096030	0.000000	54.10
54.20	03440	MAMMOGRAPHY	0	2,277,609	2,277,609	0.176194	0.000000	54.20
56.00	05600	RADIOISOTOPE	180,026	3,255,695	3,435,721	0.098776	0.000000	56.00
57.00	05700	CT SCAN	1,930,992	17,071,896	19,002,888	0.049186	0.000000	57.00
58.00	05800	MRI	451,191	8,791,887	9,243,078	0.067441	0.000000	58.00
60.00	06000	LABORATORY	4,713,692	28,501,962	33,215,654	0.081929	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	157,497	384,517	542,014	0.307320	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	610,244	894,036	1,504,280	0.381610	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	563,649	3,273,821	3,837,470	0.376272	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	438,890	1,425,005	1,863,895	0.242308	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	71,134	837,239	908,373	0.715078	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	750,286	5,026,835	5,777,121	0.068848	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,997	2,240,443	2,251,440	0.179444	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,785,851	4,899,922	8,685,773	0.147186	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,888,211	1,863,017	6,751,228	0.189355	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,398,359	7,148,541	11,546,900	0.163713	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	115,256	115,256	1.048275	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	468	407,718	408,186	0.375579	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,478,204	10,985,944	12,464,148	0.249778	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	210,099	1,584,655	1,794,754	0.874735	0.000000	92.00
200.00		Subtotal (see instructions)	39,773,737	125,535,770	165,309,507			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,773,737	125,535,770	165,309,507			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/19/2016 2:53 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.10	03630	ULTRA SOUND	0.000000		54.10
54.20	03440	MAMMOGRAPHY	0.000000		54.20
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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	DIABETES SERVICES	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	550,251	0	550,251	3,771	145.92	30.00
31.00	INTENSIVE CARE UNIT	150,454		150,454	919	163.71	31.00
43.00	NURSERY	0		0	387	0.00	43.00
200.00	Total (lines 30-199)	700,705		700,705	5,077		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	1,469	214,356				30.00
31.00	INTENSIVE CARE UNIT	486	79,563				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	1,955	293,919				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	712,034	17,473,515	0.040749	1,633,325	66,556	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	24,122	2,483,860	0.009711	223,501	2,170	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	189,080	6,419,684	0.029453	373,326	10,996	54.00
54.10	03630	ULTRA SOUND	25,783	4,014,219	0.006423	98,227	631	54.10
54.20	03440	MAMMOGRAPHY	90,698	2,277,609	0.039822	0	0	54.20
56.00	05600	RADIOISOTOPE	12,240	3,435,721	0.003563	123,916	442	56.00
57.00	05700	CT SCAN	277,328	19,002,888	0.014594	1,097,570	16,018	57.00
58.00	05800	MRI	290,486	9,243,078	0.031427	217,613	6,839	58.00
60.00	06000	LABORATORY	203,351	33,215,654	0.006122	2,657,230	16,268	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,251	542,014	0.009688	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	33,199	1,504,280	0.022070	357,320	7,886	65.00
66.00	06600	PHYSICAL THERAPY	138,621	3,837,470	0.036123	248,926	8,992	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,617	1,863,895	0.020718	179,804	3,725	67.00
68.00	06800	SPEECH PATHOLOGY	68,354	908,373	0.075249	52,193	3,927	68.00
69.00	06900	ELECTROCARDIOLOGY	23,321	5,777,121	0.004037	475,413	1,919	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	85,945	2,251,440	0.038173	10,997	420	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	75,386	8,685,773	0.008679	2,017,799	17,512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,890	6,751,228	0.006057	2,355,674	14,268	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,724	11,546,900	0.008636	2,088,274	18,034	73.00
76.00	03950	DIABETES SERVICES	6,293	115,256	0.054600	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	34,653	408,186	0.084895	468	40	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	232,813	12,464,148	0.018679	905,276	16,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	161,823	1,794,754	0.090164	120,975	10,908	92.00
200.00		Total (lines 50-199)	2,870,012	156,017,066		15,237,827	224,461	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
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	3,771	0.00	1,469	0		30.00
31.00	03100	INTENSIVE CARE UNIT	919	0.00	486	0		31.00
43.00	04300	NURSERY	387	0.00	0	0		43.00
200.00		Total (lines 30-199)	5,077		1,955	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.10	03630	ULTRA SOUND	0	0	0	0	0	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETES SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	17,473,515	0.000000	0.000000	1,633,325	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,483,860	0.000000	0.000000	223,501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,419,684	0.000000	0.000000	373,326	54.00
54.10	03630	ULTRA SOUND	0	4,014,219	0.000000	0.000000	98,227	54.10
54.20	03440	MAMMOGRAPHY	0	2,277,609	0.000000	0.000000	0	54.20
56.00	05600	RADIOISOTOPE	0	3,435,721	0.000000	0.000000	123,916	56.00
57.00	05700	CT SCAN	0	19,002,888	0.000000	0.000000	1,097,570	57.00
58.00	05800	MRI	0	9,243,078	0.000000	0.000000	217,613	58.00
60.00	06000	LABORATORY	0	33,215,654	0.000000	0.000000	2,657,230	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	542,014	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,504,280	0.000000	0.000000	357,320	65.00
66.00	06600	PHYSICAL THERAPY	0	3,837,470	0.000000	0.000000	248,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,863,895	0.000000	0.000000	179,804	67.00
68.00	06800	SPEECH PATHOLOGY	0	908,373	0.000000	0.000000	52,193	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,777,121	0.000000	0.000000	475,413	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,251,440	0.000000	0.000000	10,997	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,685,773	0.000000	0.000000	2,017,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,751,228	0.000000	0.000000	2,355,674	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,546,900	0.000000	0.000000	2,088,274	73.00
76.00	03950	DIABETES SERVICES	0	115,256	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	408,186	0.000000	0.000000	468	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	12,464,148	0.000000	0.000000	905,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,794,754	0.000000	0.000000	120,975	92.00
200.00		Total (lines 50-199)	0	156,017,066			15,237,827	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,945,795	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	387,557	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,461,925	0		54.00
54.10	03630	ULTRA SOUND	0	795,307	0		54.10
54.20	03440	MAMMOGRAPHY	0	112,871	0		54.20
56.00	05600	RADIOISOTOPE	0	1,225,846	0		56.00
57.00	05700	CT SCAN	0	7,438,580	0		57.00
58.00	05800	MRI	0	2,299,897	0		58.00
60.00	06000	LABORATORY	0	3,390,905	0		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	375,621	0		65.00
66.00	06600	PHYSICAL THERAPY	0	408	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	625	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	90,158	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,955,762	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	604,759	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,010,168	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	427,854	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	507,817	0		73.00
76.00	03950	DIABETES SERVICES	0	1,992	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	238,932	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	2,876,378	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	600,368	0		92.00
200.00		Total (lines 50-199)	0	28,749,525	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.281060	2,945,795	0	0	827,945	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.132199	387,557	0	0	51,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180057	1,461,925	0	0	263,230	54.00
54.10	03630	ULTRA SOUND	0.096030	795,307	0	0	76,373	54.10
54.20	03440	MAMMOGRAPHY	0.176194	112,871	6,000	0	19,887	54.20
56.00	05600	RADIOISOTOPE	0.098776	1,225,846	0	0	121,084	56.00
57.00	05700	CT SCAN	0.049186	7,438,580	0	34,636	365,874	57.00
58.00	05800	MRI	0.067441	2,299,897	0	0	155,107	58.00
60.00	06000	LABORATORY	0.081929	3,390,905	0	0	277,813	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.307320	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.381610	375,621	0	0	143,341	65.00
66.00	06600	PHYSICAL THERAPY	0.376272	408	0	0	154	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242308	625	0	0	151	67.00
68.00	06800	SPEECH PATHOLOGY	0.715078	90,158	0	0	64,470	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068848	1,955,762	0	0	134,650	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179444	604,759	0	0	108,520	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.147186	1,010,168	0	0	148,683	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.189355	427,854	0	0	81,016	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163713	507,817	0	0	83,136	73.00
76.00	03950	DIABETES SERVICES	1.048275	1,992	0	0	2,088	76.00
76.97	07697	CARDIAC REHABILITATION	0.375579	238,932	0	0	89,738	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.249778	2,876,378	0	0	718,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.874735	600,368	0	0	525,163	92.00
200.00		Subtotal (see instructions)		28,749,525	6,000	34,636	4,258,114	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		28,749,525	6,000	34,636	4,258,114	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.10	03630	ULTRA SOUND	0	0		54.10
54.20	03440	MAMMOGRAPHY	1,057	0		54.20
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	1,704		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	DIABETES SERVICES	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
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)	1,057	1,704		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,057	1,704		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,431	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,771	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,662	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)	660	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,469	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)	353	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)	5,338,322	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)	5,338,322	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)	5,338,322	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)	1,415.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,079,560	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,079,560	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,794,310	919	1,952.46	486	948,896	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)	2,649,136	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,677,592	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)	293,919	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	224,461	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	518,380	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,159,212	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,109	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,415.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,569,934	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	550,251	5,338,322	0.103076	1,569,934	161,823	90.00
91.00	Nursing School cost	0	5,338,322	0.000000	1,569,934	0	91.00
92.00	Allied health cost	0	5,338,322	0.000000	1,569,934	0	92.00
93.00	All other Medical Education	0	5,338,322	0.000000	1,569,934	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,122,868		30.00
31.00	03100	INTENSIVE CARE UNIT		1,416,690		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.281060	1,633,325	459,062	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.227704	223,501	50,892	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180057	373,326	67,220	54.00
54.10	03630	ULTRA SOUND	0.096030	98,227	9,433	54.10
54.20	03440	MAMMOGRAPHY	0.176194	0	0	54.20
56.00	05600	RADIOISOTOPE	0.098776	123,916	12,240	56.00
57.00	05700	CT SCAN	0.049186	1,097,570	53,985	57.00
58.00	05800	MRI	0.067441	217,613	14,676	58.00
60.00	06000	LABORATORY	0.081940	2,657,230	217,733	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.307320	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.381610	357,320	136,357	65.00
66.00	06600	PHYSICAL THERAPY	0.376272	248,926	93,664	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242308	179,804	43,568	67.00
68.00	06800	SPEECH PATHOLOGY	0.715078	52,193	37,322	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068848	475,413	32,731	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179444	10,997	1,973	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.147186	2,017,799	296,992	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.189355	2,355,674	446,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163713	2,088,274	341,878	73.00
76.00	03950	DIABETES SERVICES	1.048275	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.375579	468	176	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.251143	905,276	227,354	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.874735	120,975	105,821	92.00
200.00		Total (sum of lines 50-94 and 96-98)		15,237,827	2,649,136	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)		15,237,827		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140161 | Component CCN: 14U161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Swing Beds - SNF | 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	0.281060	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.132199	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.180057	3,682	663	54.00
54.10	03630	ULTRA SOUND	0.096030	2,883	277	54.10
54.20	03440	MAMMOGRAPHY	0.176194	0	0	54.20
56.00	05600	RADIOISOTOPE	0.098776	0	0	56.00
57.00	05700	CT SCAN	0.049186	9,202	453	57.00
58.00	05800	MRI	0.067441	0	0	58.00
60.00	06000	LABORATORY	0.081929	70,864	5,806	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.307320	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.381610	4,383	1,673	65.00
66.00	06600	PHYSICAL THERAPY	0.376272	79,048	29,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242308	73,598	17,833	67.00
68.00	06800	SPEECH PATHOLOGY	0.715078	1,734	1,240	68.00
69.00	06900	ELECTROCARDIOLOGY	0.068848	265	18	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179444	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.147186	70,059	10,312	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.189355	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.163713	163,721	26,803	73.00
76.00	03950	DIABETES SERVICES	1.048275	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.375579	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.249778	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.874735	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		479,439	94,822	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)		479,439		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

			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)		4,560,577			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)		10,560			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		1,031,067			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		37.15			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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

			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)		1.60			30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.81			31.00
32.00	Sum of lines 30 and 31		27.41			32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.83			33.00
34.00	Disproportionate share adjustment (see instructions)		134,879			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		0.000033685	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		257,611	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		257,611	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		257,611			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)		4,963,627			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		5,978,261			48.00
49.00	Total payment for inpatient operating costs (see instructions)		5,978,261			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		366,157			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,344,418			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,344,418			61.00
62.00	Deductibles billed to program beneficiaries		611,900			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		0			63.00
64.00	Allowable bad debts (see instructions)		118,055			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		76,736			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		101,604			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,809,254			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)		63,883			70.93
70.94	HRR adjustment amount (see instructions)		0			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)	2015	1,003,776			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)		6,876,913			71.00
71.01	Sequestration adjustment (see instructions)		137,538			71.01
72.00	Interim payments		6,739,762			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)		-387			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		316,771			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: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/19/2016 2:53 pm

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: 140161	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/19/2016 2:53 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,761	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,258,114	2.00
3.00	PPS payments	4,645,842	3.00
4.00	Outlier payment (see instructions)	2,288	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)	2,761	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	40,636	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)	40,636	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)	40,636	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	37,875	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)	2,761	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)	4,648,130	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,052,977	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)	3,597,914	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)	3,597,914	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,597,914	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)	213,887	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	139,027	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	194,187	36.00
37.00	Subtotal (see instructions)	3,736,941	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,736,941	40.00
40.01	Sequestration adjustment (see instructions)	74,739	40.01
41.00	Interim payments	3,651,617	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	10,585	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,739,762		3,651,617	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,739,762		3,651,617	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		10,585	6.01
6.02	SETTLEMENT TO PROGRAM		387		0	6.02
7.00	Total Medicare program liability (see instructions)		6,739,375		3,662,202	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: 140161 | Component CCN: 14U161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Swing Beds - SNF | 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		88,267		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		88,267		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		88,267		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140161	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/19/2016 2:53 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,410	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,955	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	440	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,581	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	165,309,507	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,765,680	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140161 | Component CCN: 14U161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-2 | Date/Time Prepared: 2/19/2016 2:53 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	95,108	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	353	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	95,108	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	95,108	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	95,108	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,040	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	90,068	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	90,068	0	19.00
19.01	Sequestration adjustment (see instructions)	1,801	0	19.01
20.00	Interim payments	88,267	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/19/2016 2:53 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	749,860	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	31,341,342	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-21,832,916	0	0	0	6.00
7.00	Inventory	540,638	0	0	0	7.00
8.00	Prepaid expenses	27,076	0	0	0	8.00
9.00	Other current assets	999,465	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)	11,825,465	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	600,013	0	0	0	12.00
13.00	Land improvements	2,287,903	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,006,533	0	0	0	15.00
16.00	Accumulated depreciation	-21,015,599	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-2,116,993	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	27,871,074	0	0	0	23.00
24.00	Accumulated depreciation	-20,528,963	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	495	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,104,463	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	25,737,373	626,581	851,709	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	228,662	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	25,966,035	626,581	851,709	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	62,895,963	626,581	851,709	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,504,968	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,044	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	522,125	0	0	0	43.00
44.00	Other current liabilities	6,046,482	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,076,619	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	67,678	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	67,678	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	8,144,297	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	54,751,666				52.00
53.00	Specific purpose fund		626,581			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			851,709		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)	54,751,666	626,581	851,709	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	62,895,963	626,581	851,709	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/19/2016 2:53 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		49,604,604		1,152,390		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,147,062				2.00
3.00	Total (sum of line 1 and line 2)		54,751,666		1,152,390		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	INCREASE IN RESTRICTED ASSETS	0		24,380		0	5.00
6.00	CONTRIBUTIONS TEMP RESTRICTED	0		233,418		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		257,798		10.00
11.00	Subtotal (line 3 plus line 10)		54,751,666		1,410,188		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	DECREASE IN RESTRICTED ASSETS	0		783,607		31,608	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		783,607		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		54,751,666		626,581		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	883,317		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)	883,317		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	INCREASE IN RESTRICTED ASSETS		0			5.00
6.00	CONTRIBUTIONS TEMP RESTRICTED		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)	883,317		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	DECREASE IN RESTRICTED ASSETS		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	31,608		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	851,709		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140161 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/19/2016 2:53 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,749,527		6,749,527	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,749,527		6,749,527	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,542,914		2,542,914	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)	2,542,914		2,542,914	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,292,441		9,292,441	17.00
18.00	Ancillary services	30,472,159	125,019,331	155,491,490	18.00
19.00	Outpatient services	468	522,974	523,442	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 & OTHER NRCC	961,267	40,470,240	41,431,507	27.00
27.01	OCCUPATIONAL HEALTH	0	400,734	400,734	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	40,726,335	166,413,279	207,139,614	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		67,724,264		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)		67,724,264		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140161	Period: From 10/01/2014 To 09/30/2015	Worksheet G-3 Date/Time Prepared: 2/19/2016 2:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	207,139,614	1.00
2.00	Less contractual allowances and discounts on patients' accounts	139,434,368	2.00
3.00	Net patient revenues (line 1 minus line 2)	67,705,246	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	67,724,264	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-19,018	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,193,008	6.00
7.00	Income from investments	1,275,087	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	140,992	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	1,352,846	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	10,861	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,140,676	24.00
24.01	RESEARCH & RENTAL OF PHYS OFFICES	52,610	24.01
25.00	Total other income (sum of lines 6-24)	5,166,080	25.00
26.00	Total (line 5 plus line 25)	5,147,062	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)	5,147,062	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140161	Period: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prepared: 2/19/2016 2:53 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	364,659	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	1,498	1.01
2.00	Capital DRG outlier payments	0	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)	9.90	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)	366,157	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