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: 140275	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/17/2015 1:27 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/17/2015 Time: 1:27 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 GENESIS MEDICAL CENTER - SILVIS (140275) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 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	127,750	-5,313	393,513	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
200.00	Total	0	127,750	-5,313	393,513	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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2015 1:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 HOSPITAL ROAD	PO Box:			1.00
2.00	City: SILVIS	State: IL	Zip Code: 61282-	County: ROCK ISLAND	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	GENESIS MEDICAL CENTER - SILVIS	140275	19340	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	ILLINI RESTORATIVE CARE CENTER	145703	19340		09/03/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	2,427	381	0	80	306	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2015 1:25 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2015 1:25 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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/17/2015 1:25 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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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.	N			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	222,507	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2015 1:25 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	H55790	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: GENESIS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 05001	141.00
142.00	Street: 1227 E. RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	143.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	06/30/2015	170.00

		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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/17/2015 1:25 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/08/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/17/2015 1:25 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.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARTIN	ORWITZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175	ORWITZM@GENESISHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/17/2015 1:25 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)	10/08/2015			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)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2015 1:25 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	138	50,370	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)		138	50,370	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	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)		145	52,925	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	92	30,736		0	19.00
20.00	NURSING FACILITY	45.00	28	13,064		0	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)		265				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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/17/2015 1:25 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)	5,572	1,216	11,116			1.00
2.00	HMO and other (see instructions)	1,478	1,360				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,572	1,216	11,116			7.00
8.00	INTENSIVE CARE UNIT	491	76	1,004			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		542	1,016			13.00
14.00	Total (see instructions)	6,063	1,834	13,136	0.00	414.47	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	7,561	5,384	27,190	0.00	77.64	19.00
20.00	NURSING FACILITY		0	8,954	0.00	9.91	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	502.02	27.00
28.00	Observation Bed Days		27	1,750			28.00
29.00	Ambulance Trips	3,577					29.00
30.00	Employee discount days (see instruction)			179			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/17/2015 1:25 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	1,745	1,029	3,812	1.00
2.00	HMO and other (see instructions)			378	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,745	1,029	3,812	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/17/2015 1:25 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	27,721,802	0	27,721,802	944,940.00	29.34	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	2,866,752	79,011	2,945,763	156,482.00	18.82	9.00
10.00	Excluded area salaries (see instructions)		2,903,350	442,174	3,345,524	188,698.00	17.73	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		567,573	0	567,573	6,082.00	93.32	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		254,321	0	254,321	2,750.00	92.48	13.00
14.00	Home office salaries & wage-related costs		7,593,228	0	7,593,228	174,494.00	43.52	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)		5,290,742	0	5,290,742			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,399,429	0	1,399,429			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	222,221	0	222,221	4,372.00	50.83	26.00
27.00	Administrative & General	5.00	943,747	0	943,747	20,740.00	45.50	27.00
28.00	Administrative & General under contract (see inst.)		144,240	0	144,240	1,141.00	126.42	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	757,181	0	757,181	37,189.00	20.36	30.00
31.00	Laundry & Linen Service	8.00	48,395	-18,091	30,304	2,326.00	13.03	31.00
32.00	Housekeeping	9.00	251,564	-7,617	243,947	17,760.00	13.74	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	597,171	-495,477	101,694	7,193.00	14.14	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	552,548	0	552,548	17,513.00	31.55	38.00
39.00	Central Services and Supply	14.00	102,020	0	102,020	7,272.00	14.03	39.00
40.00	Pharmacy	15.00	1,463,576	0	1,463,576	34,398.00	42.55	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/17/2015 1:25 pm

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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 11/17/2015 1:25 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)		27,866,042	0	27,866,042	946,081.00	29.45	1.00
2.00	Excluded area salaries (see instructions)		5,770,102	521,185	6,291,287	345,180.00	18.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,095,940	-521,185	21,574,755	600,901.00	35.90	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,415,122	0	8,415,122	183,326.00	45.90	4.00
5.00	Subtotal wage-related costs (see inst.)		5,290,742	0	5,290,742	0.00	24.52	5.00
6.00	Total (sum of lines 3 thru 5)		35,801,804	-521,185	35,280,619	784,227.00	44.99	6.00
7.00	Total overhead cost (see instructions)		5,082,663	-521,185	4,561,478	149,904.00	30.43	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 11/17/2015 1:25 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	857,851	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)	2,422,633	8.00
9.00	Prescription Drug Plan	479,298	9.00
10.00	Dental, Hearing and Vision Plan	196,861	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	32,904	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)	108,602	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	461,731	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,008,904	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	210	22.00
23.00	Tuition Reimbursement	121,178	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,690,172	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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 11/17/2015 1:25 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	711,814	0	1.00
2.00	Hospital	711,814	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-7 | Date/Time Prepared: 11/17/2015 1:25 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.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	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	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	1,035	0	1,035	12.00
13.00		RUB	701	0	701	13.00
14.00		RUA	1,398	0	1,398	14.00
15.00		RVC	986	0	986	15.00
16.00		RVB	873	0	873	16.00
17.00		RVA	1,542	0	1,542	17.00
18.00		RHC	250	0	250	18.00
19.00		RHB	165	0	165	19.00
20.00		RHA	251	0	251	20.00
21.00		RMC	40	0	40	21.00
22.00		RMB	20	0	20	22.00
23.00		RMA	93	0	93	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	0	0	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	6	0	6	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	2	0	2	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	24	0	24	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	9	0	9	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	29	0	29	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	1	0	1	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	7	0	7	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	1	0	1	47.00
48.00		CD1	1	0	1	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	13	0	13	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	59	0	59	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	12	0	12	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	7	0	7	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-7 | Date/Time Prepared: 11/17/2015 1:25 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	12	0	12	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	5	0	5	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	3	0	3	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	12	0	12	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	4	0	4	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		7,561	0	7,561	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).	19340		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	2,806,531	40.31	N	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	615	0.01	N	204.00
205.00	Training	4,954	0.07	N	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	6,963,174			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/17/2015 1:25 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)	0.329924	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,159,152	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	43,153,789	6.00
7.00	Medicaid cost (line 1 times line 6)	14,237,471	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)	4,078,319	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)	4,078,319	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,950,074	0	3,950,074	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,303,224	0	1,303,224	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,303,224	0	1,303,224	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)	3,474,807	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	295,999	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,178,808	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,048,765	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,351,989	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,430,308	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,744,823	1,744,823	-94,055	1,650,768	1.00
1.01	00101	NEW CAP RELATED IRC		467,829	467,829	0	467,829	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,405,296	2,405,296	0	2,405,296	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	222,221	3,946,683	4,168,904	0	4,168,904	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	943,747	20,351,744	21,295,491	0	21,295,491	5.00
7.00	00700	OPERATION OF PLANT	757,181	2,286,987	3,044,168	0	3,044,168	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	48,395	55,643	104,038	-38,892	65,146	8.00
9.00	00900	HOUSEKEEPING	251,564	494,125	745,689	-22,578	723,111	9.00
10.00	01000	DIETARY	597,171	2,401,335	2,998,506	-2,487,887	510,619	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	552,548	54,023	606,571	0	606,571	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	102,020	253,759	355,779	0	355,779	14.00
15.00	01500	PHARMACY	1,463,576	221,971	1,685,547	0	1,685,547	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,460,192	2,361,116	7,821,308	-337,180	7,484,128	30.00
31.00	03100	INTENSIVE CARE UNIT	774,809	181,103	955,912	0	955,912	31.00
43.00	04300	NURSERY	0	0	0	337,180	337,180	43.00
44.00	04400	SKILLED NURSING FACILITY	2,866,752	1,207,504	4,074,256	483,924	4,558,180	44.00
45.00	04500	NURSING FACILITY	337,776	30,814	368,590	283,662	652,252	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,495,571	1,178,352	2,673,923	0	2,673,923	50.00
53.00	05300	ANESTHESIOLOGY	0	408,761	408,761	0	408,761	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	905,869	142,664	1,048,533	0	1,048,533	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	65,434	189,757	255,191	0	255,191	55.00
57.00	05700	CT SCAN	193,563	70,443	264,006	0	264,006	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	86,785	17,031	103,816	0	103,816	58.00
59.00	05900	CARDIAC CATHETERIZATION	447,186	389,996	837,182	0	837,182	59.00
60.00	06000	LABORATORY	2,079,065	3,636,909	5,715,974	0	5,715,974	60.00
65.00	06500	RESPIRATORY THERAPY	1,017,884	282,597	1,300,481	0	1,300,481	65.00
66.00	06600	PHYSICAL THERAPY	1,969,148	386,950	2,356,098	0	2,356,098	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,315,950	4,315,950	-1,796,541	2,519,409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,796,541	1,796,541	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,512,748	3,512,748	0	3,512,748	73.00
76.00	03020	CARDIAC REHAB	309,220	146,453	455,673	0	455,673	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	78,220	8,101	86,321	0	86,321	90.00
90.01	09001	WOUND CENTER	101,072	207,911	308,983	0	308,983	90.01
91.00	09100	EMERGENCY	2,029,259	3,657,791	5,687,050	0	5,687,050	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,328,356	998,213	3,326,569	3,841	3,330,410	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,484,584	58,015,382	85,499,966	-1,871,985	83,627,981	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,216	38,216	10,339	48,555	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,260	405,824	428,084	4,482	432,566	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	98,612	98,612	192.01
194.00	07950	CROSSTOWN SQUARE	142,178	394,019	536,197	288,567	824,764	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	980,896	980,896	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	489,089	489,089	194.03
194.04	07951	OUTREACH	72,780	14,283	87,063	0	87,063	194.04
200.00		TOTAL (SUM OF LINES 118-199)	27,721,802	58,867,724	86,589,526	0	86,589,526	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,663,378	3,314,146		1.00
1.01	00101	NEW CAP RELATED IRC	-155,566	312,263		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,405,296		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0	0		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,398,076	2,770,828		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,083,606	12,211,885		5.00
7.00	00700	OPERATION OF PLANT	-19,643	3,024,525		7.00
7.01	00701	OPERATION OF PLANT IRC	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	65,146		8.00
9.00	00900	HOUSEKEEPING	-45,189	677,922		9.00
10.00	01000	DIETARY	0	510,619		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	606,571		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	458,357	814,136		14.00
15.00	01500	PHARMACY	-23,568	1,661,979		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	972,640	972,640		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,195,323	6,288,805		30.00
31.00	03100	INTENSIVE CARE UNIT	-14,925	940,987		31.00
43.00	04300	NURSERY	0	337,180		43.00
44.00	04400	SKILLED NURSING FACILITY	-143,486	4,414,694		44.00
45.00	04500	NURSING FACILITY	0	652,252		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-153,500	2,520,423		50.00
53.00	05300	ANESTHESIOLOGY	-378,973	29,788		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,048,533		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	255,191		55.00
57.00	05700	CT SCAN	0	264,006		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	103,816		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	837,182		59.00
60.00	06000	LABORATORY	-303	5,715,671		60.00
65.00	06500	RESPIRATORY THERAPY	-43,168	1,257,313		65.00
66.00	06600	PHYSICAL THERAPY	-174,373	2,181,725		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,519,409		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,796,541		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,512,748		73.00
76.00	03020	CARDIAC REHAB	-22,138	433,535		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-150	86,171		90.00
90.01	09001	WOUND CENTER	-33,422	275,561		90.01
91.00	09100	EMERGENCY	-3,232,427	2,454,623		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,082,390	2,248,020		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,105,851	69,522,130		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	48,555		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	432,566		192.00
192.01	19201	NONREIMBURSABLE	0	98,612		192.01
194.00	07950	CROSSTOWN SQUARE	-84,859	739,905		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	980,896		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	489,089		194.03
194.04	07951	OUTREACH	0	87,063		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-14,190,710	72,398,816		200.00

RECLASSIFICATIONS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/17/2015 1:25 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - POB DEPRECIATION					
1.00	NONREIMBURSABLE	192.01	0	94,055		1.00
	0		0	94,055		
	B - NURSING HOME OVERHEAD COSTS					
1.00	NURSING FACILITY	45.00	45,965	53,077		1.00
	0		45,965	53,077		
	C - NURSERY COSTS					
1.00	NURSERY	43.00	277,588	59,592		1.00
	0		277,588	59,592		
	D - CHARGEABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,796,541		1.00
	0		0	1,796,541		
	E - DIETARY COST AND EMPLOYEE MEALS					
1.00	SKILLED NURSING FACILITY	44.00	109,457	440,147		1.00
2.00	NURSING FACILITY	45.00	36,045	144,946		2.00
3.00	CROSSTOWN SQUARE	194.00	57,219	230,088		3.00
4.00	NONALLOWABLE PHYSICIAN	194.02	195,351	785,545		4.00
5.00	NONALLOWABLE GUEST MEALS	194.03	97,405	391,684		5.00
	0		495,477	1,992,410		
	F - RECLASS HOUSEKEEPING COST					
1.00	AMBULANCE SERVICES	95.00	1,296	2,545		1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	3,488	6,851		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,296	2,545		3.00
4.00	NONREIMBURSABLE	192.01	1,537	3,020		4.00
	0		7,617	14,961		
	G - RECLASS LAUNDRY COST					
1.00	SKILLED NURSING FACILITY	44.00	15,519	17,843		1.00
2.00	NURSING FACILITY	45.00	1,688	1,941		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	298	343		3.00
4.00	CROSSTOWN SQUARE	194.00	586	674		4.00
	0		18,091	20,801		
500.00	Grand Total: Increases		844,738	4,031,437		500.00

RECLASSIFICATIONS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/17/2015 1:25 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - POB DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	94,055	9		1.00
	0		0	94,055			
	B - NURSING HOME OVERHEAD COSTS						
1.00	SKILLED NURSING FACILITY	44.00	45,965	53,077	0		1.00
	0		45,965	53,077			
	C - NURSERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	277,588	59,592	0		1.00
	0		277,588	59,592			
	D - CHARGEABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,796,541	0		1.00
	0		0	1,796,541			
	E - DIETARY COST AND EMPLOYEE MEALS						
1.00	DIETARY	10.00	495,477	1,992,410	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		495,477	1,992,410			
	F - RECLASS HOUSEKEEPING COST						
1.00	HOUSEKEEPING	9.00	7,617	14,961	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		7,617	14,961			
	G - RECLASS LAUNDRY COST						
1.00	LAUNDRY & LINEN SERVICE	8.00	18,091	20,801	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		18,091	20,801			
500.00	Grand Total: Decreases		844,738	4,031,437			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/17/2015 1:25 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	2,374,122	0	0	0	0	1.00
2.00	Land Improvements	1,836,222	3,115,861	0	3,115,861	0	2.00
3.00	Buildings and Fixtures	57,078,678	3,163,480	0	3,163,480	0	3.00
4.00	Building Improvements	16,771	2,073,823	0	2,073,823	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	45,000,085	2,110,185	0	2,110,185	39,001	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	106,305,878	10,463,349	0	10,463,349	39,001	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	106,305,878	10,463,349	0	10,463,349	39,001	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,374,122	0	1.00
2.00	Land Improvements	4,952,083	0	2.00
3.00	Buildings and Fixtures	60,242,158	0	3.00
4.00	Building Improvements	2,090,594	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	47,071,269	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	116,730,226	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	116,730,226	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 11/17/2015 1:25 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,744,823	0	0	0	0	1.00
1.01	NEW CAP RELATED IRC	467,829	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,405,296	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	4,617,948	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,744,823		1.00
1.01	NEW CAP RELATED IRC	0	467,829		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,405,296		2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0		2.01
3.00	Total (sum of lines 1-2)	0	4,617,948		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/17/2015 1:25 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	67,284,834	0	67,284,834	0.588380	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	47,071,269	0	47,071,269	0.411620	0	2.01
3.00	Total (sum of lines 1-2)	114,356,103	0	114,356,103	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,314,212	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	467,829	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,405,296	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	6,187,337	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-66	0	0	0	3,314,146	1.00
1.01	NEW CAP RELATED IRC	-155,566	0	0	0	312,263	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,405,296	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	-155,632	0	0	0	6,031,705	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/17/2015 1:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP RELATED IRC (chapter 2)		0	NEW CAP RELATED IRC	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP IRC (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,002,724			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	-887,918			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP RELATED IRC		0	NEW CAP RELATED IRC	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP IRC		0	CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/17/2015 1:25 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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	AMBULANCE - CPE REVENUE	B	-23,581	AMBULANCE SERVICES	95.00	0	33.00
34.00	AMBULANCE - MISCELLANEOUS REVENUE	B	-640,673	AMBULANCE SERVICES	95.00	0	34.00
35.00	AMBULANCE OUTREACH - MISCELLANEOUS R	B	-418,099	AMBULANCE SERVICES	95.00	0	35.00
35.03	PEDIATRICS - MISCELLANEOUS REVENUE	B	-248	ADULTS & PEDIATRICS	30.00	0	35.03
35.05	PHYSICAL THERAPY - MISCELLANEOUS REV	B	-2,943	PHYSICAL THERAPY	66.00	0	35.05
35.07	P.T. CLINIC - KING PLAZA MOLIN - INT	B	-98,648	PHYSICAL THERAPY	66.00	0	35.07
35.08	P.T. CLINIC - KING PLAZA MOLIN - MIS	B	-7,920	PHYSICAL THERAPY	66.00	0	35.08
35.11	TRAUMA - MISCELLANEOUS REVENUE	B	-42,749	EMERGENCY	91.00	0	35.11
35.13	CARDIAC REHAB - MISCELLANEOUS REVENU	B	-22,138	CARDIAC REHAB	76.00	0	35.13
35.14	DIABETES CARE CENTER - MISCELLANEOUS	B	-150	CLINIC	90.00	0	35.14
36.03	PHARMACY - INTERCOMPANY REVENUE	B	-21,018	PHARMACY	15.00	0	36.03
36.07	ADMINISTRATION - RENTAL INCOME -3RD	B	-34,894	ADMINISTRATIVE & GENERAL	5.00	0	36.07
36.08	ADMINISTRATION - DISCOUNTS EARNED	B	-6,866	ADMINISTRATIVE & GENERAL	5.00	0	36.08
36.09	INFORMATION TECHNOLOGY - MISCELLANEO	B	-7,249	ADMINISTRATIVE & GENERAL	5.00	9	36.09
36.10	MEDICAL STAFF - ILLINI - MISCELLANEO	B	-35,200	ADMINISTRATIVE & GENERAL	5.00	0	36.10
36.11	ENVIRONMENTAL SERVICES - INTERCOMPAN	B	-45,189	HOUSEKEEPING	9.00	0	36.11
36.13	BIRTH ASSOCIATES - MISCELLANEOUS REV	B	-2,640	ADULTS & PEDIATRICS	30.00	0	36.13
36.14	GROUNDS - INTERCOMPANY REVENUE	B	-3,528	OPERATION OF PLANT	7.00	0	36.14
36.15	MAINTENANCE - INTERCOMPANY REVENUE	B	-16,115	OPERATION OF PLANT	7.00	0	36.15
36.18	GRANTS 2 - MISCELLANEOUS REVENUE	B	-28,723	ADMINISTRATIVE & GENERAL	5.00	0	36.18
36.20	SWITCHBOARD - MISCELLANEOUS REVENUE	B	-1,012	ADMINISTRATIVE & GENERAL	5.00	0	36.20
36.21	PHYSICIAN SUPPORT SVCS - RENT 3RD PA	B	-127,461	ADMINISTRATIVE & GENERAL	5.00	10	36.21
37.00	PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-1,320	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.06	INTEREST - INTEREST EXPENSE - 2010 B	A	-230,770	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	37.06
37.07	INTEREST - INTEREST EXP CAP INT OFF	A	230,704	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	37.07
37.09	INTEREST- IRC - INTEREST EXPENSE - R	A	-155,566	NEW CAP RELATED IRC	1.01	11	37.09
37.10	INTEREST - CS - INTEREST EXPENSE - R	A	-57,538	CROSSTOWN SQUARE	194.00	0	37.10
37.11	NURSING FLOOR - IRC MEDICARE - CONTR	A	-64,291	SKILLED NURSING FACILITY	44.00	0	37.11
37.12	ENVIRONMENTAL SVCS - IRC - CONTRACT	A	-61,246	SKILLED NURSING FACILITY	44.00	0	37.12
37.14	ENVIRONMENTAL SVC - CS - CONTRACT FE	A	-1,412	CROSSTOWN SQUARE	194.00	0	37.14
38.00			0		0.00	0	38.00
39.00			0		0.00	0	39.00
39.01	SECURITY - IRC - CONTRACT FEES- ILLI	A	-17,136	SKILLED NURSING FACILITY	44.00	0	39.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/17/2015 1:25 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	
39.02	SECURITY - CS - CONTRACT FEES-ILLIN	A	-8,028	CROSSTOWN SQUARE	194.00	0	39.02
39.03	ADMINISTRATION - PHYSICIAN PRACTICE	A	-1,910,529	ADMINISTRATIVE & GENERAL	5.00	0	39.03
39.04			0		0.00	0	39.04
40.00	PHYSICIAN SUPPORT SVCS - RENTAL FACI	A	-146,899	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN SUPPORT SVCS - RENTAL EQUI	A	-876	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	PHYSICIAN SUPPORT SVCS - TELEPHONE -	A	-79	ADMINISTRATIVE & GENERAL	5.00	0	42.00
42.01	PHYSICIAN SUPPORT SVCS - LD PHONE	A	-18	ADMINISTRATIVE & GENERAL	5.00	0	42.01
43.00	ALCOHOL	A	-49	ADMINISTRATIVE & GENERAL	5.00	0	43.00
43.02	LABORATORY - ADVERTISING & PROMOTION	A	-66	LABORATORY	60.00	0	43.02
43.03	PHYSICAL THERAPY - ADVERTISING & PRO	A	-4,772	PHYSICAL THERAPY	66.00	0	43.03
43.04	P.T. CLINIC - KING PLAZA MOLIN - ADV	A	-4,446	PHYSICAL THERAPY	66.00	0	43.04
43.06	WOUND CENTER - ADVERTISING & PROMOTI	A	-27	WOUND CENTER	90.01	0	43.06
43.07	ADMINISTRATION - ADVERTISING & PROMO	A	-15	ADMINISTRATIVE & GENERAL	5.00	0	43.07
43.09	CORP COMMUNICATION - CS - ADVERTISIN	A	-17,881	CROSSTOWN SQUARE	194.00	0	43.09
43.10	ADMINISTRATION - PROVIDER TAX ASSESS	A	-2,641,080	ADMINISTRATIVE & GENERAL	5.00	0	43.10
43.11	NURSING ADMIN - IRC - PROVIDER TAX A	A	-106,962	ADMINISTRATIVE & GENERAL	5.00	0	43.11
43.12	ADMINISTRATOR - IRC - PROVIDER TAX A	A	-46,104	ADMINISTRATIVE & GENERAL	5.00	0	43.12
43.13	SELF INSURANCE	A	-1,398,076	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.13
43.14	LOBBYING	A	-5,865	ADMINISTRATIVE & GENERAL	5.00	0	43.14
43.15			0		0.00	0	43.15
44.00	PHYSICAL THERAPY RENTAL INCOME	B	-55,644	PHYSICAL THERAPY	66.00	0	44.00
44.01	ADMINISTRATOR IRC DISCOUNTS EARNED	B	-46	ADMINISTRATIVE & GENERAL	5.00	0	44.01
44.02	PHARMACY - VENDOR REBATE	B	-2,550	PHARMACY	15.00	0	44.02
44.03	CCU - MISC REVENUE	B	-3,387	INTENSIVE CARE UNIT	31.00	0	44.03
44.04	LABORATORY - MISC REVENUE	B	-237	LABORATORY	60.00	0	44.04
44.05	NURSING FLOOR IRC - MISC REVENUE	B	-148	SKILLED NURSING FACILITY	44.00	0	44.05
44.06	DISTRIBUTION - MISC REVENUE	B	-665	SKILLED NURSING FACILITY	44.00	0	44.06
45.00			0		0.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03			0		0.00	0	45.03
45.04			0		0.00	0	45.04
45.05			0		0.00	0	45.05
45.06			0		0.00	0	45.06
45.07			0		0.00	0	45.07
45.08			0		0.00	0	45.08
45.09			0		0.00	0	45.09
45.10			0		0.00	0	45.10
45.11			0		0.00	0	45.11
45.12			0		0.00	0	45.12
45.13			0		0.00	0	45.13
45.14			0		0.00	0	45.14
45.15			0		0.00	0	45.15
45.16			0		0.00	0	45.16
45.17			0		0.00	0	45.17
45.18			0		0.00	0	45.18
45.19			0		0.00	0	45.19
45.20			0		0.00	0	45.20
45.21			0		0.00	0	45.21
45.22			0		0.00	0	45.22
45.23			0		0.00	0	45.23

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/17/2015 1:25 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	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,190,710				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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/17/2015 1:25 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	GHS HOME OFFICE COSTS	9,572,956	13,555,315	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	GHS HOME OFFICE COSTS	1,663,444	0	2.00
3.00	0.00			0	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	GHS HOME OFFICE COSTS	458,357	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	GHS HOME OFFICE COSTS	972,640	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00		GHS HOME OFFICE COSTS	0	0	4.04
5.00	0		0	12,667,397	13,555,315	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	C		0.00	GENESIS HEALTH SYSTEM	100.00	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: 140275	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-1 Date/Time Prepared: 11/17/2015 1:25 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	-3,982,359	0		1.00
2.00	1,663,444	9		2.00
3.00	0	0		3.00
4.00	458,357	0		4.00
4.01	972,640	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	-887,918			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/17/2015 1:25 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	60.00	LABORATORY	126,600	0	126,600	219,500	1,200	1.00
2.00	65.00	RESPIRATORY THERAPY	46,106	43,168	2,938	171,400	36	2.00
3.00	91.00	EMERGENCY	3,200,226	3,189,676	10,550	171,400	128	3.00
4.00	30.00	ADULTS & PEDIATRICS	1,192,435	1,192,435	0	0	0	4.00
5.00	50.00	OPERATING ROOM	153,500	153,500	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	11,538	11,538	0	0	0	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	102,412	0	102,412	171,400	1,243	7.00
8.00	90.01	WOUND CENTER	33,395	33,395	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	378,973	378,973	0	0	0	9.00
10.00	95.00	AMBULANCE SERVICES	11,821	0	11,821	171,400	143	10.00
200.00			5,257,006	5,002,685	254,321		2,750	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	60.00	LABORATORY	126,635	6,332	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	2,967	148	0	0	0	2.00
3.00	91.00	EMERGENCY	10,548	527	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	102,428	5,121	0	0	0	7.00
8.00	90.01	WOUND CENTER	0	0	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	95.00	AMBULANCE SERVICES	11,784	589	0	0	0	10.00
200.00			254,362	12,717	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	60.00	LABORATORY	0	126,635	0	0		1.00
2.00	65.00	RESPIRATORY THERAPY	0	2,967	0	43,168		2.00
3.00	91.00	EMERGENCY	0	10,548	2	3,189,678		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,192,435		4.00
5.00	50.00	OPERATING ROOM	0	0	0	153,500		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	11,538		6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	0	102,428	0	0		7.00
8.00	90.01	WOUND CENTER	0	0	0	33,395		8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	378,973		9.00
10.00	95.00	AMBULANCE SERVICES	0	11,784	37	37		10.00
200.00			0	254,362	39	5,002,724		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,314,146	3,314,146				1.00
1.01	00101	NEW CAP RELATED IRC	312,263	0	312,263			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,405,296			2,405,296		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0			0	0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,770,828	8,062	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,211,885	773,792	0	180,302	0	5.00
7.00	00700	OPERATION OF PLANT	3,024,525	312,813	0	88,309	0	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	13,361	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	65,146	34,464	1,078	0	0	8.00
9.00	00900	HOUSEKEEPING	677,922	15,721	2,359	5,523	0	9.00
10.00	01000	DIETARY	510,619	76,026	0	6,659	0	10.00
11.00	01100	CAFETERIA	0	42,209	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	606,571	11,229	0	2,609	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	814,136	96,281	0	97,518	0	14.00
15.00	01500	PHARMACY	1,661,979	66,798	0	106,445	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	972,640	39,618	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	15,893	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,288,805	619,235	0	215,414	0	30.00
31.00	03100	INTENSIVE CARE UNIT	940,987	53,842	0	39,338	0	31.00
43.00	04300	NURSERY	337,180	31,225	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,414,694	0	178,286	18,284	0	44.00
45.00	04500	NURSING FACILITY	652,252	0	85,893	18,466	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,520,423	231,878	0	281,668	0	50.00
53.00	05300	ANESTHESIOLOGY	29,788	0	0	58,104	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,048,533	127,521	0	245,503	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	255,191	0	0	0	0	55.00
57.00	05700	CT SCAN	264,006	0	0	153,332	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	103,816	2,620	0	6,364	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	837,182	34,666	0	243,403	0	59.00
60.00	06000	LABORATORY	5,715,671	215,712	0	155,226	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,257,313	40,482	0	120,377	0	65.00
66.00	06600	PHYSICAL THERAPY	2,181,725	48,745	24,060	30,528	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,519,409	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,796,541	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,512,748	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	433,535	125,246	0	12,929	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	86,171	0	0	0	0	90.00
90.01	09001	WOUND CENTER	275,561	27,252	0	3,758	0	90.01
91.00	09100	EMERGENCY	2,454,623	127,204	0	61,071	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,248,020	102,227	0	252,365	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,522,130	3,280,761	305,037	2,403,495	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,555	22,962	2,109	620	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	432,566	10,423	0	1,181	0	192.00
192.01	19201	NONREIMBURSABLE	98,612	0	5,117	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	739,905	0	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	980,896	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	489,089	0	0	0	0	194.03
194.04	07951	OUTREACH	87,063	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	72,398,816	3,314,146	312,263	2,405,296	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,778,890					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	95,368	13,261,347	13,261,347			5.00
7.00	00700	OPERATION OF PLANT	76,515	3,502,162	785,346	4,287,508		7.00
7.01	00701	OPERATION OF PLANT IRC	0	13,361	2,996	0	16,357	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,062	103,750	23,266	66,577	59	8.00
9.00	00900	HOUSEKEEPING	24,651	726,176	162,842	30,368	129	9.00
10.00	01000	DIETARY	10,276	603,580	135,350	146,864	0	10.00
11.00	01100	CAFETERIA	0	42,209	9,465	81,539	0	11.00
13.00	01300	NURSING ADMINISTRATION	55,836	676,245	151,645	21,692	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,309	1,018,244	228,337	185,993	0	14.00
15.00	01500	PHARMACY	147,897	1,983,119	444,707	129,038	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,012,258	226,995	76,533	0	16.00
17.00	01700	SOCIAL SERVICE	0	15,893	3,564	30,702	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	523,716	7,647,170	1,714,852	1,196,216	0	30.00
31.00	03100	INTENSIVE CARE UNIT	78,296	1,112,463	249,465	104,009	0	31.00
43.00	04300	NURSERY	28,051	396,456	88,904	60,320	0	43.00
44.00	04400	SKILLED NURSING FACILITY	306,365	4,917,629	1,102,759	0	9,757	44.00
45.00	04500	NURSING FACILITY	33,901	790,512	177,269	0	4,700	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151,130	3,185,099	714,246	447,934	0	50.00
53.00	05300	ANESTHESIOLOGY	0	87,892	19,709	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,540	1,513,097	339,306	246,340	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,612	261,803	58,708	0	0	55.00
57.00	05700	CT SCAN	19,560	436,898	97,973	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,770	121,570	27,262	5,061	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	45,189	1,160,440	260,224	66,966	0	59.00
60.00	06000	LABORATORY	210,094	6,296,703	1,412,010	416,704	0	60.00
65.00	06500	RESPIRATORY THERAPY	102,859	1,521,031	341,085	78,201	0	65.00
66.00	06600	PHYSICAL THERAPY	198,986	2,484,044	557,037	94,164	1,317	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,519,409	564,967	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,796,541	402,867	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,512,748	787,720	0	0	73.00
76.00	03020	CARDIAC REHAB	31,247	602,957	135,211	241,946	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,904	94,075	21,096	0	0	90.00
90.01	09001	WOUND CENTER	10,214	316,785	71,038	52,644	0	90.01
91.00	09100	EMERGENCY	205,061	2,847,959	638,643	245,728	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	235,416	2,838,028	636,416	197,478	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,718,825	69,419,653	12,593,280	4,223,017	15,962	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	352	74,598	16,728	44,357	115	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,410	446,580	100,144	20,134	0	192.00
192.01	19201	NONREIMBURSABLE	155	103,884	23,296	0	280	192.01
194.00	07950	CROSSTOWN SQUARE	20,209	760,114	170,453	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	19,741	1,000,637	224,389	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	9,843	498,932	111,884	0	0	194.03
194.04	07951	OUTREACH	7,355	94,418	21,173	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,778,890	72,398,816	13,261,347	4,287,508	16,357	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	193,652					8.00
9.00	00900	HOUSEKEEPING	0	919,515				9.00
10.00	01000	DIETARY	0	34,545	920,339			10.00
11.00	01100	CAFETERIA	0	19,179	682,085	834,477		11.00
13.00	01300	NURSING ADMINISTRATION	0	5,102	0	13,997	868,681	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,545	43,749	0	5,818	0	14.00
15.00	01500	PHARMACY	0	10,355	0	27,495	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,002	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,222	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,206	281,370	225,771	163,840	518,592	30.00
31.00	03100	INTENSIVE CARE UNIT	3,978	24,465	12,483	22,076	67,043	31.00
43.00	04300	NURSERY	12,364	14,188	0	8,162	380	43.00
44.00	04400	SKILLED NURSING FACILITY	63,433	0	0	129,064	0	44.00
45.00	04500	NURSING FACILITY	6,262	0	0	16,474	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,980	105,362	0	45,049	102,893	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,533	57,944	0	27,129	88	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,679	0	55.00
57.00	05700	CT SCAN	3,722	0	0	5,220	20	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	829	1,191	0	2,011	13	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,904	15,752	0	7,713	10,163	59.00
60.00	06000	LABORATORY	22	57,891	0	74,938	3,946	60.00
65.00	06500	RESPIRATORY THERAPY	2,117	18,394	0	32,898	335	65.00
66.00	06600	PHYSICAL THERAPY	1,683	26,421	0	53,494	181	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	30	38,646	0	8,345	11,750	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,527	103	90.00
90.01	09001	WOUND CENTER	224	12,383	0	3,940	9,759	90.01
91.00	09100	EMERGENCY	26,613	57,800	0	52,314	138,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	46,450	0	97,912	4,470	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	192,445	896,411	920,339	802,095	868,681	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,749	0	199	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,207	4,736	0	1,247	0	192.00
192.01	19201	NONREIMBURSABLE	0	5,619	0	83	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	10,506	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	11,038	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	5,502	0	194.03
194.04	07951	OUTREACH	0	0	0	3,807	0	194.04
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)	193,652	919,515	920,339	834,477	868,681	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
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
14.00	01400	CENTRAL SERVICES & SUPPLY	1,483,686					14.00
15.00	01500	PHARMACY	7,277	2,601,991				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,333,788			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	57,381		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,431	0	108,573	34,493	11,991,514	30.00
31.00	03100	INTENSIVE CARE UNIT	13,112	0	21,406	1,260	1,631,760	31.00
43.00	04300	NURSERY	0	0	8,201	3,591	592,566	43.00
44.00	04400	SKILLED NURSING FACILITY	23,542	0	49,300	0	6,295,484	44.00
45.00	04500	NURSING FACILITY	823	0	9,359	0	1,005,399	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,104	0	99,749	18,037	4,856,453	50.00
53.00	05300	ANESTHESIOLOGY	4,750	0	17,872	0	130,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,796	0	61,006	0	2,260,239	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,360	0	13,148	0	366,698	55.00
57.00	05700	CT SCAN	9,139	0	101,869	0	654,841	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	365	0	22,178	0	180,480	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,975	0	49,559	0	1,585,696	59.00
60.00	06000	LABORATORY	341,043	0	190,466	0	8,793,723	60.00
65.00	06500	RESPIRATORY THERAPY	15,779	0	85,556	0	2,095,396	65.00
66.00	06600	PHYSICAL THERAPY	1,778	0	49,312	0	3,269,431	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	457,113	0	53,788	0	3,595,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	325,959	0	39,978	0	2,565,345	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,601,991	120,564	0	7,023,023	73.00
76.00	03020	CARDIAC REHAB	551	0	4,438	0	1,043,874	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	851	0	118,652	90.00
90.01	09001	WOUND CENTER	3,855	0	12,430	0	483,058	90.01
91.00	09100	EMERGENCY	35,206	0	154,324	0	4,197,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	12,668	0	53,667	0	3,887,089	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,483,626	2,601,991	1,327,594	57,381	68,623,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	148,746	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	574,048	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	133,162	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	6,194	0	947,267	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	1,236,064	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	616,318	194.03
194.04	07951	OUTREACH	60	0	0	0	119,458	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,483,686	2,601,991	1,333,788	57,381	72,398,816	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP RELATED IRC				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT IRC				7.01
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
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	11,991,514		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,631,760		31.00
43.00	04300	NURSERY	0	592,566		43.00
44.00	04400	SKILLED NURSING FACILITY	0	6,295,484		44.00
45.00	04500	NURSING FACILITY	0	1,005,399		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,856,453		50.00
53.00	05300	ANESTHESIOLOGY	0	130,223		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,260,239		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	366,698		55.00
57.00	05700	CT SCAN	0	654,841		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	180,480		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,585,696		59.00
60.00	06000	LABORATORY	0	8,793,723		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,095,396		65.00
66.00	06600	PHYSICAL THERAPY	0	3,269,431		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,595,277		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,565,345		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,023,023		73.00
76.00	03020	CARDIAC REHAB	0	1,043,874		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	118,652		90.00
90.01	09001	WOUND CENTER	0	483,058		90.01
91.00	09100	EMERGENCY	0	4,197,532		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	3,887,089		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	68,623,753		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	148,746		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	574,048		192.00
192.01	19201	NONREIMBURSABLE	0	133,162		192.01
194.00	07950	CROSSTOWN SQUARE	0	947,267		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	1,236,064		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	616,318		194.03
194.04	07951	OUTREACH	0	119,458		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	72,398,816		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,062	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	298,344	773,792	0	180,302	0	5.00
7.00	00700	OPERATION OF PLANT	542,167	312,813	0	88,309	0	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	13,361	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,464	1,078	0	0	8.00
9.00	00900	HOUSEKEEPING	18,187	15,721	2,359	5,523	0	9.00
10.00	01000	DIETARY	25,250	76,026	0	6,659	0	10.00
11.00	01100	CAFETERIA	0	42,209	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,660	11,229	0	2,609	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	103,231	96,281	0	97,518	0	14.00
15.00	01500	PHARMACY	76,117	66,798	0	106,445	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,618	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	15,893	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	73,194	619,235	0	215,414	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,190	53,842	0	39,338	0	31.00
43.00	04300	NURSERY	0	31,225	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	36,721	0	178,286	18,284	0	44.00
45.00	04500	NURSING FACILITY	800	0	85,893	18,466	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,424	231,878	0	281,668	0	50.00
53.00	05300	ANESTHESIOLOGY	350	0	0	58,104	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,516	127,521	0	245,503	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,576	0	0	0	0	55.00
57.00	05700	CT SCAN	344	0	0	153,332	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,293	2,620	0	6,364	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	37,120	34,666	0	243,403	0	59.00
60.00	06000	LABORATORY	185,264	215,712	0	155,226	0	60.00
65.00	06500	RESPIRATORY THERAPY	41,867	40,482	0	120,377	0	65.00
66.00	06600	PHYSICAL THERAPY	158,624	48,745	24,060	30,528	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	112,911	125,246	0	12,929	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,050	0	0	0	0	90.00
90.01	09001	WOUND CENTER	42,363	27,252	0	3,758	0	90.01
91.00	09100	EMERGENCY	29,269	127,204	0	61,071	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	129,604	102,227	0	252,365	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,025,436	3,280,761	305,037	2,403,495	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	450	22,962	2,109	620	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	162,218	10,423	0	1,181	0	192.00
192.01	19201	NONREIMBURSABLE	0	0	5,117	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	2,666	0	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,190,770	3,314,146	312,263	2,405,296	0	202.00

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		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,062	8,062				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,252,438	277	1,252,715			5.00
7.00	00700	OPERATION OF PLANT	943,289	222	74,186	1,017,697		7.00
7.01	00701	OPERATION OF PLANT IRC	13,361	0	283	0	13,644	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	35,542	9	2,198	15,803	49	8.00
9.00	00900	HOUSEKEEPING	41,790	71	15,383	7,208	108	9.00
10.00	01000	DIETARY	107,935	30	12,786	34,860	0	10.00
11.00	01100	CAFETERIA	42,209	0	894	19,354	0	11.00
13.00	01300	NURSING ADMINISTRATION	19,498	162	14,325	5,149	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	297,030	30	21,569	44,148	0	14.00
15.00	01500	PHARMACY	249,360	429	42,008	30,629	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,618	0	21,443	18,166	0	16.00
17.00	01700	SOCIAL SERVICE	15,893	0	337	7,288	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	907,843	1,523	161,996	283,938	0	30.00
31.00	03100	INTENSIVE CARE UNIT	104,370	227	23,565	24,688	0	31.00
43.00	04300	NURSERY	31,225	81	8,398	14,318	0	43.00
44.00	04400	SKILLED NURSING FACILITY	233,291	888	104,170	0	8,138	44.00
45.00	04500	NURSING FACILITY	105,159	98	16,745	0	3,921	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	587,970	438	67,470	106,323	0	50.00
53.00	05300	ANESTHESIOLOGY	58,454	0	1,862	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	381,540	265	32,052	58,472	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,576	19	5,546	0	0	55.00
57.00	05700	CT SCAN	153,676	57	9,255	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	16,277	25	2,575	1,201	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	315,189	131	24,582	15,895	0	59.00
60.00	06000	LABORATORY	556,202	609	133,383	98,910	0	60.00
65.00	06500	RESPIRATORY THERAPY	202,726	298	32,220	18,562	0	65.00
66.00	06600	PHYSICAL THERAPY	261,957	577	52,620	22,351	1,098	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	53,369	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	38,056	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	74,411	0	0	73.00
76.00	03020	CARDIAC REHAB	251,086	91	12,772	57,429	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,050	23	1,993	0	0	90.00
90.01	09001	WOUND CENTER	73,373	30	6,710	12,496	0	90.01
91.00	09100	EMERGENCY	217,544	595	60,328	58,327	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	484,196	683	60,118	46,874	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,014,729	7,888	1,189,608	1,002,389	13,314	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,141	1	1,580	10,529	96	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	173,822	7	9,460	4,779	0	192.00
192.01	19201	NONREIMBURSABLE	5,117	0	2,201	0	234	192.01
194.00	07950	CROSSTOWN SQUARE	2,666	59	16,101	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	57	21,196	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	29	10,569	0	0	194.03
194.04	07951	OUTREACH	0	21	2,000	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,222,475	8,062	1,252,715	1,017,697	13,644	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	53,601					8.00
9.00	00900	HOUSEKEEPING	0	64,560				9.00
10.00	01000	DIETARY	0	2,425	158,036			10.00
11.00	01100	CAFETERIA	0	1,347	117,124	180,928		11.00
13.00	01300	NURSING ADMINISTRATION	0	358	0	3,035	42,527	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	428	3,072	0	1,261	0	14.00
15.00	01500	PHARMACY	0	727	0	5,961	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,264	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	507	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,637	19,755	38,768	35,526	25,388	30.00
31.00	03100	INTENSIVE CARE UNIT	1,101	1,718	2,144	4,786	3,282	31.00
43.00	04300	NURSERY	3,422	996	0	1,770	19	43.00
44.00	04400	SKILLED NURSING FACILITY	17,559	0	0	27,983	0	44.00
45.00	04500	NURSING FACILITY	1,733	0	0	3,572	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,914	7,398	0	9,767	5,037	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,192	4,068	0	5,882	4	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	364	0	55.00
57.00	05700	CT SCAN	1,030	0	0	1,132	1	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230	84	0	436	1	58.00
59.00	05900	CARDIAC CATHETERIZATION	527	1,106	0	1,672	498	59.00
60.00	06000	LABORATORY	6	4,065	0	16,248	193	60.00
65.00	06500	RESPIRATORY THERAPY	586	1,291	0	7,133	16	65.00
66.00	06600	PHYSICAL THERAPY	466	1,855	0	11,598	9	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	8	2,713	0	1,809	575	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	548	5	90.00
90.01	09001	WOUND CENTER	62	869	0	854	478	90.01
91.00	09100	EMERGENCY	7,366	4,058	0	11,342	6,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,261	0	21,229	219	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,267	62,937	158,036	173,908	42,527	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	895	0	43	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	334	333	0	270	0	192.00
192.01	19201	NONREIMBURSABLE	0	395	0	18	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	2,278	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	2,393	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	1,193	0	194.03
194.04	07951	OUTREACH	0	0	0	825	0	194.04
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)	53,601	64,560	158,036	180,928	42,527	202.00

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		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
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
14.00	01400	CENTRAL SERVICES & SUPPLY	367,538					14.00
15.00	01500	PHARMACY	1,803	330,917				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	80,491			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	24,025		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,199	0	6,552	14,441	1,521,566	30.00
31.00	03100	INTENSIVE CARE UNIT	3,248	0	1,292	528	170,949	31.00
43.00	04300	NURSERY	0	0	495	1,504	62,228	43.00
44.00	04400	SKILLED NURSING FACILITY	5,832	0	2,975	0	400,836	44.00
45.00	04500	NURSING FACILITY	204	0	565	0	131,997	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,018	0	6,019	7,552	832,906	50.00
53.00	05300	ANESTHESIOLOGY	1,177	0	1,078	0	62,571	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	940	0	3,681	0	490,096	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,769	0	793	0	19,067	55.00
57.00	05700	CT SCAN	2,264	0	6,147	0	173,562	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	90	0	1,338	0	22,257	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,214	0	2,991	0	365,805	59.00
60.00	06000	LABORATORY	84,482	0	11,500	0	905,598	60.00
65.00	06500	RESPIRATORY THERAPY	3,909	0	5,163	0	271,904	65.00
66.00	06600	PHYSICAL THERAPY	440	0	2,976	0	355,947	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,238	0	3,246	0	169,853	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	80,746	0	2,412	0	121,214	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	330,917	7,275	0	412,603	73.00
76.00	03020	CARDIAC REHAB	136	0	268	0	326,887	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	51	0	4,670	90.00
90.01	09001	WOUND CENTER	955	0	750	0	96,577	90.01
91.00	09100	EMERGENCY	8,721	0	9,312	0	384,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,138	0	3,238	0	622,956	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	367,523	330,917	80,117	24,025	7,926,444	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	39,285	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	189,005	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	7,965	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	374	0	21,478	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	23,646	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	11,791	194.03
194.04	07951	OUTREACH	15	0	0	0	2,861	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	367,538	330,917	80,491	24,025	8,222,475	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP RELATED IRC				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT IRC				7.01
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
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,521,566		30.00
31.00	03100	INTENSIVE CARE UNIT	0	170,949		31.00
43.00	04300	NURSERY	0	62,228		43.00
44.00	04400	SKILLED NURSING FACILITY	0	400,836		44.00
45.00	04500	NURSING FACILITY	0	131,997		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	832,906		50.00
53.00	05300	ANESTHESIOLOGY	0	62,571		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	490,096		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	19,067		55.00
57.00	05700	CT SCAN	0	173,562		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,257		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	365,805		59.00
60.00	06000	LABORATORY	0	905,598		60.00
65.00	06500	RESPIRATORY THERAPY	0	271,904		65.00
66.00	06600	PHYSICAL THERAPY	0	355,947		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	169,853		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	121,214		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	412,603		73.00
76.00	03020	CARDIAC REHAB	0	326,887		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	4,670		90.00
90.01	09001	WOUND CENTER	0	96,577		90.01
91.00	09100	EMERGENCY	0	384,395		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	622,956		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,926,444		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,285		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	189,005		192.00
192.01	19201	NONREIMBURSABLE	0	7,965		192.01
194.00	07950	CROSSTOWN SQUARE	0	21,478		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	23,646		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	11,791		194.03
194.04	07951	OUTREACH	0	2,861		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	8,222,475		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP RELATED IRC (SQUARE FEET IRC)	NEW MVBLE EQUIP (DOLLAR VALUE)	MVBLE EQUIP IRC (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	230,211					1.00
1.01	00101	NEW CAP RELATED IRC	0	52,420				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,245,936			2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC			0	0		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	560	0	0	0	27,499,582	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,750	0	168,356	0	943,747	5.00
7.00	00700	OPERATION OF PLANT	21,729	0	82,458	0	757,181	7.00
7.01	00701	OPERATION OF PLANT IRC	0	2,243	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,394	181	0	0	30,305	8.00
9.00	00900	HOUSEKEEPING	1,092	396	5,157	0	243,947	9.00
10.00	01000	DIETARY	5,281	0	6,218	0	101,693	10.00
11.00	01100	CAFETERIA	2,932	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	780	0	2,436	0	552,548	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	91,057	0	102,020	14.00
15.00	01500	PHARMACY	4,640	0	99,393	0	1,463,576	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,014	0	201,142	0	5,182,604	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	0	36,732	0	774,809	31.00
43.00	04300	NURSERY	2,169	0	0	0	277,588	43.00
44.00	04400	SKILLED NURSING FACILITY	0	29,929	17,073	0	3,031,753	44.00
45.00	04500	NURSING FACILITY	0	14,419	17,243	0	335,485	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,107	0	263,006	0	1,495,571	50.00
53.00	05300	ANESTHESIOLOGY	0	0	54,254	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	229,237	0	905,869	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	65,434	55.00
57.00	05700	CT SCAN	0	0	143,173	0	193,563	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	5,942	0	86,785	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	227,277	0	447,186	59.00
60.00	06000	LABORATORY	14,984	0	144,942	0	2,079,065	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	0	112,402	0	1,017,884	65.00
66.00	06600	PHYSICAL THERAPY	3,386	4,039	28,505	0	1,969,148	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	8,700	0	12,072	0	309,220	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	78,220	90.00
90.01	09001	WOUND CENTER	1,893	0	3,509	0	101,072	90.01
91.00	09100	EMERGENCY	8,836	0	57,025	0	2,029,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,101	0	235,645	0	2,329,652	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	227,892	51,207	2,244,254	0	26,905,184	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,595	354	579	0	3,488	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	1,103	0	23,854	192.00
192.01	19201	NONREIMBURSABLE	0	859	0	0	1,537	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	0	199,983	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	195,351	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	97,405	194.03
194.04	07951	OUTREACH	0	0	0	0	72,780	194.04
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)	3,314,146	312,263	2,405,296	0	2,778,890	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.396124	5.956944	1.070955	0.000000	0.101052	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					8,062	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000293	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT IRC (SQUARE FEET IRC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,261,347	59,137,469				5.00
7.00	00700	OPERATION OF PLANT	0	3,502,162	154,172			7.00
7.01	00701	OPERATION OF PLANT IRC	0	13,361	0	50,177		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,750	2,394	181	713,245	8.00
9.00	00900	HOUSEKEEPING	0	726,176	1,092	396	0	9.00
10.00	01000	DIETARY	0	603,580	5,281	0	0	10.00
11.00	01100	CAFETERIA	0	42,209	2,932	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	676,245	780	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,018,244	6,688	0	5,691	14.00
15.00	01500	PHARMACY	0	1,983,119	4,640	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,012,258	2,752	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	15,893	1,104	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,647,170	43,014	0	114,934	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,112,463	3,740	0	14,650	31.00
43.00	04300	NURSERY	0	396,456	2,169	0	45,538	43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,917,629	0	29,929	233,636	44.00
45.00	04500	NURSING FACILITY	0	790,512	0	14,419	23,065	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,185,099	16,107	0	92,005	50.00
53.00	05300	ANESTHESIOLOGY	0	87,892	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,513,097	8,858	0	42,477	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	261,803	0	0	0	55.00
57.00	05700	CT SCAN	0	436,898	0	0	13,708	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	121,570	182	0	3,054	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,160,440	2,408	0	7,012	59.00
60.00	06000	LABORATORY	0	6,296,703	14,984	0	80	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,521,031	2,812	0	7,799	65.00
66.00	06600	PHYSICAL THERAPY	0	2,484,044	3,386	4,039	6,198	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,519,409	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,796,541	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,512,748	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	602,957	8,700	0	110	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	94,075	0	0	0	90.00
90.01	09001	WOUND CENTER	0	316,785	1,893	0	825	90.01
91.00	09100	EMERGENCY	0	2,847,959	8,836	0	98,018	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,838,028	7,101	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-13,261,347	56,158,306	151,853	48,964	708,800	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74,598	1,595	354	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	446,580	724	0	4,445	192.00
192.01	19201	NONREIMBURSABLE	0	103,884	0	859	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	760,114	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	1,000,637	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	498,932	0	0	0	194.03
194.04	07951	OUTREACH	0	94,418	0	0	0	194.04
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)		13,261,347	4,287,508	16,357	193,652	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.224246	27.809901	0.325986	0.271508	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,252,715	1,017,697	13,644	53,601	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.021183	6.601049	0.271917	0.075151	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/17/2015 1:25 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	140,569					9.00
10.00	01000	DIETARY	5,281	156,665				10.00
11.00	01100	CAFETERIA	2,932	116,108	50,199			11.00
13.00	01300	NURSING ADMINISTRATION	780	0	842	344,734		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	350	0	8,177,415	14.00
15.00	01500	PHARMACY	1,583	0	1,654	0	40,108	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,014	38,432	9,856	205,801	382,672	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	2,125	1,328	26,606	72,265	31.00
43.00	04300	NURSERY	2,169	0	491	151	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	7,764	0	129,754	44.00
45.00	04500	NURSING FACILITY	0	0	991	0	4,536	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,107	0	2,710	40,833	623,380	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	26,178	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	1,632	35	20,922	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	101	0	172,845	55.00
57.00	05700	CT SCAN	0	0	314	8	50,371	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	121	5	2,012	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	464	4,033	71,512	59.00
60.00	06000	LABORATORY	8,850	0	4,508	1,566	1,879,676	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	0	1,979	133	86,968	65.00
66.00	06600	PHYSICAL THERAPY	4,039	0	3,218	72	9,800	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,519,400	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,796,541	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	5,908	0	502	4,663	3,035	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	152	41	0	90.00
90.01	09001	WOUND CENTER	1,893	0	237	3,873	21,248	90.01
91.00	09100	EMERGENCY	8,836	0	3,147	55,140	194,041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,101	0	5,890	1,774	69,822	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	137,037	156,665	48,251	344,734	8,177,086	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,949	0	12	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	75	0	0	192.00
192.01	19201	NONREIMBURSABLE	859	0	5	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	632	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	664	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	331	0	0	194.03
194.04	07951	OUTREACH	0	0	229	0	329	194.04
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)	919,515	920,339	834,477	868,681	1,483,686	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.541378	5.874567	16.623379	2.519859	0.181437	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,560	158,036	180,928	42,527	367,538	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.459276	1.008751	3.604215	0.123362	0.044945	205.00

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		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
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
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	3,512,748				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	206,385,141			16.00
17.00	01700	SOCIAL SERVICE	0	0	7,877		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	16,799,155	4,735		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,312,153	173		31.00
43.00	04300	NURSERY	0	1,268,885	493		43.00
44.00	04400	SKILLED NURSING FACILITY	0	7,628,095	0		44.00
45.00	04500	NURSING FACILITY	0	1,448,060	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	15,433,813	2,476		50.00
53.00	05300	ANESTHESIOLOGY	0	2,765,352	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,439,208	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,034,363	0		55.00
57.00	05700	CT SCAN	0	15,761,867	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,431,571	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,668,186	0		59.00
60.00	06000	LABORATORY	0	29,482,190	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	13,237,892	0		65.00
66.00	06600	PHYSICAL THERAPY	0	7,629,928	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,322,443	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,185,637	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,512,748	18,654,448	0		73.00
76.00	03020	CARDIAC REHAB	0	686,710	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	131,639	0		90.00
90.01	09001	WOUND CENTER	0	1,923,297	0		90.01
91.00	09100	EMERGENCY	0	23,878,081	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	8,303,765	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,512,748	205,426,738	7,877		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	NONREIMBURSABLE	0	0	0		192.01
194.00	07950	CROSSTOWN SQUARE	0	958,403	0		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0		194.03
194.04	07951	OUTREACH	0	0	0		194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,601,991	1,333,788	57,381		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.740728	0.006463	7.284626		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	330,917	80,491	24,025		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.094205	0.000390	3.050019		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 1:25 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	11,991,514		11,991,514	0	11,991,514	30.00
31.00	03100	INTENSIVE CARE UNIT	1,631,760		1,631,760	0	1,631,760	31.00
43.00	04300	NURSERY	592,566		592,566	0	592,566	43.00
44.00	04400	SKILLED NURSING FACILITY	6,295,484		6,295,484	0	6,295,484	44.00
45.00	04500	NURSING FACILITY	1,005,399		1,005,399	0	1,005,399	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,856,453		4,856,453	0	4,856,453	50.00
53.00	05300	ANESTHESIOLOGY	130,223		130,223	0	130,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,260,239		2,260,239	0	2,260,239	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	366,698		366,698	0	366,698	55.00
57.00	05700	CT SCAN	654,841		654,841	0	654,841	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	180,480		180,480	0	180,480	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,585,696		1,585,696	0	1,585,696	59.00
60.00	06000	LABORATORY	8,793,723		8,793,723	0	8,793,723	60.00
65.00	06500	RESPIRATORY THERAPY	2,095,396	0	2,095,396	0	2,095,396	65.00
66.00	06600	PHYSICAL THERAPY	3,269,431	0	3,269,431	0	3,269,431	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,595,277		3,595,277	0	3,595,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,565,345		2,565,345	0	2,565,345	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,023,023		7,023,023	0	7,023,023	73.00
76.00	03020	CARDIAC REHAB	1,043,874		1,043,874	0	1,043,874	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	118,652		118,652	0	118,652	90.00
90.01	09001	WOUND CENTER	483,058		483,058	0	483,058	90.01
91.00	09100	EMERGENCY	4,197,532		4,197,532	2	4,197,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,631,053		1,631,053		1,631,053	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,887,089		3,887,089	37	3,887,126	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	70,254,806	0	70,254,806	39	70,254,845	200.00
201.00		Less Observation Beds	1,631,053		1,631,053		1,631,053	201.00
202.00		Total (see instructions)	68,623,753	0	68,623,753	39	68,623,792	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 1:25 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	16,799,155		16,799,155			30.00
31.00	03100	INTENSIVE CARE UNIT	3,312,153		3,312,153			31.00
43.00	04300	NURSERY	1,268,885		1,268,885			43.00
44.00	04400	SKILLED NURSING FACILITY	7,628,095		7,628,095			44.00
45.00	04500	NURSING FACILITY	1,448,060		1,448,060			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,576,028	9,857,785	15,433,813	0.314663	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,124,808	1,640,544	2,765,352	0.047091	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,666,609	7,772,599	9,439,208	0.239452	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	209,276	1,825,087	2,034,363	0.180252	0.000000	55.00
57.00	05700	CT SCAN	3,352,595	12,409,272	15,761,867	0.041546	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	401,926	3,029,645	3,431,571	0.052594	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,105,311	4,562,875	7,668,186	0.206789	0.000000	59.00
60.00	06000	LABORATORY	7,977,262	21,504,928	29,482,190	0.298272	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,508,130	5,729,762	13,237,892	0.158288	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,593,423	3,036,504	7,629,927	0.428501	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,509,193	3,813,250	8,322,443	0.431998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,509,808	1,675,829	6,185,637	0.414726	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,683,358	8,971,090	18,654,448	0.376480	0.000000	73.00
76.00	03020	CARDIAC REHAB	27,088	659,622	686,710	1.520109	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,751	123,888	131,639	0.901344	0.000000	90.00
90.01	09001	WOUND CENTER	37,888	1,885,409	1,923,297	0.251161	0.000000	90.01
91.00	09100	EMERGENCY	4,471,009	19,407,072	23,878,081	0.175790	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	213,335	2,358,870	2,572,205	0.634107	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,303,765	8,303,765	0.468112	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	89,431,146	118,567,796	207,998,942			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	89,431,146	118,567,796	207,998,942			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 1:25 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
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.314663		50.00
53.00	05300	ANESTHESIOLOGY	0.047091		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239452		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.180252		55.00
57.00	05700	CT SCAN	0.041546		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052594		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.206789		59.00
60.00	06000	LABORATORY	0.298272		60.00
65.00	06500	RESPIRATORY THERAPY	0.158288		65.00
66.00	06600	PHYSICAL THERAPY	0.428501		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431998		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.414726		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376480		73.00
76.00	03020	CARDIAC REHAB	1.520109		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.901344		90.00
90.01	09001	WOUND CENTER	0.251161		90.01
91.00	09100	EMERGENCY	0.175790		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.634107		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.468116		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 1:25 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	11,991,514		11,991,514	0	11,991,514	30.00
31.00	03100	INTENSIVE CARE UNIT	1,631,760		1,631,760	0	1,631,760	31.00
43.00	04300	NURSERY	592,566		592,566	0	592,566	43.00
44.00	04400	SKILLED NURSING FACILITY	6,295,484		6,295,484	0	6,295,484	44.00
45.00	04500	NURSING FACILITY	1,005,399		1,005,399	0	1,005,399	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,856,453		4,856,453	0	4,856,453	50.00
53.00	05300	ANESTHESIOLOGY	130,223		130,223	0	130,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,260,239		2,260,239	0	2,260,239	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	366,698		366,698	0	366,698	55.00
57.00	05700	CT SCAN	654,841		654,841	0	654,841	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	180,480		180,480	0	180,480	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,585,696		1,585,696	0	1,585,696	59.00
60.00	06000	LABORATORY	8,793,723		8,793,723	0	8,793,723	60.00
65.00	06500	RESPIRATORY THERAPY	2,095,396	0	2,095,396	0	2,095,396	65.00
66.00	06600	PHYSICAL THERAPY	3,269,431	0	3,269,431	0	3,269,431	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,595,277		3,595,277	0	3,595,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,565,345		2,565,345	0	2,565,345	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,023,023		7,023,023	0	7,023,023	73.00
76.00	03020	CARDIAC REHAB	1,043,874		1,043,874	0	1,043,874	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	118,652		118,652	0	118,652	90.00
90.01	09001	WOUND CENTER	483,058		483,058	0	483,058	90.01
91.00	09100	EMERGENCY	4,197,532		4,197,532	2	4,197,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,631,053		1,631,053		1,631,053	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,887,089		3,887,089	37	3,887,126	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	70,254,806	0	70,254,806	39	70,254,845	200.00
201.00		Less Observation Beds	1,631,053		1,631,053		1,631,053	201.00
202.00		Total (see instructions)	68,623,753	0	68,623,753	39	68,623,792	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 1:25 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	16,799,155		16,799,155			30.00
31.00	03100	INTENSIVE CARE UNIT	3,312,153		3,312,153			31.00
43.00	04300	NURSERY	1,268,885		1,268,885			43.00
44.00	04400	SKILLED NURSING FACILITY	7,628,095		7,628,095			44.00
45.00	04500	NURSING FACILITY	1,448,060		1,448,060			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,576,028	9,857,785	15,433,813	0.314663	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,124,808	1,640,544	2,765,352	0.047091	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,666,609	7,772,599	9,439,208	0.239452	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	209,276	1,825,087	2,034,363	0.180252	0.000000	55.00
57.00	05700	CT SCAN	3,352,595	12,409,272	15,761,867	0.041546	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	401,926	3,029,645	3,431,571	0.052594	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,105,311	4,562,875	7,668,186	0.206789	0.000000	59.00
60.00	06000	LABORATORY	7,977,262	21,504,928	29,482,190	0.298272	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,508,130	5,729,762	13,237,892	0.158288	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,593,423	3,036,504	7,629,927	0.428501	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,509,193	3,813,250	8,322,443	0.431998	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,509,808	1,675,829	6,185,637	0.414726	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,683,358	8,971,090	18,654,448	0.376480	0.000000	73.00
76.00	03020	CARDIAC REHAB	27,088	659,622	686,710	1.520109	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,751	123,888	131,639	0.901344	0.000000	90.00
90.01	09001	WOUND CENTER	37,888	1,885,409	1,923,297	0.251161	0.000000	90.01
91.00	09100	EMERGENCY	4,471,009	19,407,072	23,878,081	0.175790	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	213,335	2,358,870	2,572,205	0.634107	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,303,765	8,303,765	0.468112	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	89,431,146	118,567,796	207,998,942			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	89,431,146	118,567,796	207,998,942			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 1:25 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
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CENTER	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/17/2015 1:25 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	1,521,566	0	1,521,566	12,866	118.26	30.00
31.00	INTENSIVE CARE UNIT	170,949		170,949	1,004	170.27	31.00
43.00	NURSERY	62,228		62,228	1,016	61.25	43.00
44.00	SKILLED NURSING FACILITY	400,836		400,836	27,190	14.74	44.00
45.00	NURSING FACILITY	131,997		131,997	8,954	14.74	45.00
200.00	Total (lines 30-199)	2,287,576		2,287,576	51,030		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	5,572	658,945				30.00
31.00	INTENSIVE CARE UNIT	491	83,603				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	7,561	111,449				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30-199)	13,624	853,997				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/17/2015 1:25 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	832,906	15,433,813	0.053966	2,365,837	127,675	50.00
53.00	05300	ANESTHESIOLOGY	62,571	2,765,352	0.022627	351,776	7,960	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	490,096	9,439,208	0.051921	687,276	35,684	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	19,067	2,034,363	0.009372	143,816	1,348	55.00
57.00	05700	CT SCAN	173,562	15,761,867	0.011012	1,185,833	13,058	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,257	3,431,571	0.006486	263,564	1,709	58.00
59.00	05900	CARDIAC CATHETERIZATION	365,805	7,668,186	0.047704	1,493,617	71,252	59.00
60.00	06000	LABORATORY	905,598	29,482,190	0.030717	3,404,538	104,577	60.00
65.00	06500	RESPIRATORY THERAPY	271,904	13,237,892	0.020540	4,445,899	91,319	65.00
66.00	06600	PHYSICAL THERAPY	355,947	7,629,927	0.046651	778,170	36,302	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	169,853	8,322,443	0.020409	2,162,826	44,141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	121,214	6,185,637	0.019596	2,964,875	58,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	412,603	18,654,448	0.022118	4,942,591	109,320	73.00
76.00	03020	CARDIAC REHAB	326,887	686,710	0.476019	15,669	7,459	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,670	131,639	0.035476	3,882	138	90.00
90.01	09001	WOUND CENTER	96,577	1,923,297	0.050214	37,888	1,903	90.01
91.00	09100	EMERGENCY	384,395	23,878,081	0.016098	2,779,314	44,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	206,959	2,572,205	0.080460	126,517	10,180	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,222,871	169,238,829		28,153,888	766,866	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/17/2015 1:25 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
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
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	12,866	0.00	5,572	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,004	0.00	491	0		31.00
43.00	04300	NURSERY	1,016	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	27,190	0.00	7,561	0		44.00
45.00	04500	NURSING FACILITY	8,954	0.00	0	0		45.00
200.00		Total (lines 30-199)	51,030		13,624	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/17/2015 1:25 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/17/2015 1:25 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	15,433,813	0.000000	0.000000	2,365,837	50.00
53.00	05300	ANESTHESIOLOGY	0	2,765,352	0.000000	0.000000	351,776	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,439,208	0.000000	0.000000	687,276	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,034,363	0.000000	0.000000	143,816	55.00
57.00	05700	CT SCAN	0	15,761,867	0.000000	0.000000	1,185,833	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,431,571	0.000000	0.000000	263,564	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,668,186	0.000000	0.000000	1,493,617	59.00
60.00	06000	LABORATORY	0	29,482,190	0.000000	0.000000	3,404,538	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,237,892	0.000000	0.000000	4,445,899	65.00
66.00	06600	PHYSICAL THERAPY	0	7,629,927	0.000000	0.000000	778,170	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,322,443	0.000000	0.000000	2,162,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,185,637	0.000000	0.000000	2,964,875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,654,448	0.000000	0.000000	4,942,591	73.00
76.00	03020	CARDIAC REHAB	0	686,710	0.000000	0.000000	15,669	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	131,639	0.000000	0.000000	3,882	90.00
90.01	09001	WOUND CENTER	0	1,923,297	0.000000	0.000000	37,888	90.01
91.00	09100	EMERGENCY	0	23,878,081	0.000000	0.000000	2,779,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,572,205	0.000000	0.000000	126,517	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	169,238,829			28,153,888	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/17/2015 1:25 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	2,187,954	0		50.00
53.00	05300	ANESTHESIOLOGY	0	329,792	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,589,689	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	447,728	0		55.00
57.00	05700	CT SCAN	0	3,559,574	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	607,093	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,905,631	0		59.00
60.00	06000	LABORATORY	0	2,655,750	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,824,281	0		65.00
66.00	06600	PHYSICAL THERAPY	0	19,655	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	799,952	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	649,152	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,402,027	0		73.00
76.00	03020	CARDIAC REHAB	0	301,439	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	31,731	0		90.00
90.01	09001	WOUND CENTER	0	756,232	0		90.01
91.00	09100	EMERGENCY	0	2,786,168	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	341,244	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	24,195,092	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/17/2015 1:25 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	0.314663	2,187,954	0	0	688,468	50.00
53.00	05300	ANESTHESIOLOGY	0.047091	329,792	0	0	15,530	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239452	1,589,689	0	0	380,654	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.180252	447,728	0	0	80,704	55.00
57.00	05700	CT SCAN	0.041546	3,559,574	0	0	147,886	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052594	607,093	0	0	31,929	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.206789	1,905,631	0	0	394,064	59.00
60.00	06000	LABORATORY	0.298272	2,655,750	0	319	792,136	60.00
65.00	06500	RESPIRATORY THERAPY	0.158288	1,824,281	0	0	288,762	65.00
66.00	06600	PHYSICAL THERAPY	0.428501	19,655	0	0	8,422	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431998	799,952	0	0	345,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.414726	649,152	0	0	269,220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376480	3,402,027	0	13,787	1,280,795	73.00
76.00	03020	CARDIAC REHAB	1.520109	301,439	0	0	458,220	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.901344	31,731	0	0	28,601	90.00
90.01	09001	WOUND CENTER	0.251161	756,232	0	0	189,936	90.01
91.00	09100	EMERGENCY	0.175790	2,786,168	0	0	489,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.634107	341,244	0	0	216,385	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.468112		0			95.00
200.00		Subtotal (see instructions)		24,195,092	0	14,106	6,107,070	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		24,195,092	0	14,106	6,107,070	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/17/2015 1:25 pm

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		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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	95		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,191		73.00
76.00	03020	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	5,286		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	5,286		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/17/2015 1:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/17/2015 1:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,433,813	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,765,352	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,439,208	0.000000	0.000000	76,584	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,034,363	0.000000	0.000000	0	55.00
57.00	05700	CT SCAN	0	15,761,867	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,431,571	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,668,186	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	29,482,190	0.000000	0.000000	96,700	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,237,892	0.000000	0.000000	56,369	65.00
66.00	06600	PHYSICAL THERAPY	0	7,629,927	0.000000	0.000000	2,557,978	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,322,443	0.000000	0.000000	12,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,185,637	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,654,448	0.000000	0.000000	435,070	73.00
76.00	03020	CARDIAC REHAB	0	686,710	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	131,639	0.000000	0.000000	0	90.00
90.01	09001	WOUND CENTER	0	1,923,297	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	23,878,081	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,572,205	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	169,238,829			3,234,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/17/2015 1:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CENTER	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/17/2015 1:25 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)	12,866	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,866	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)	11,116	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,572	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	11,991,514	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)	11,991,514	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)	11,991,514	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)	932.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,193,271	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,193,271	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/17/2015 1:25 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	1,631,760	1,004	1,625.26	491	798,003	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,006,519	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	13,997,793	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)	742,548	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	766,866	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,509,414	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,488,379	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)	1,750	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	932.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,631,053	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/17/2015 1:25 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	1,521,566	11,991,514	0.126887	1,631,053	206,959	90.00
91.00	Nursing School cost	0	11,991,514	0.000000	1,631,053	0	91.00
92.00	Allied health cost	0	11,991,514	0.000000	1,631,053	0	92.00
93.00	All other Medical Education	0	11,991,514	0.000000	1,631,053	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/17/2015 1:25 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	27,190	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,190	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)	27,190	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7,561	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,295,484	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,295,484	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,295,484	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/17/2015 1:25 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	6,295,484	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	231.54	71.00
72.00	Program routine service cost (line 9 x line 71)	1,750,674	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,750,674	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,750,674	83.00
84.00	Program inpatient ancillary services (see instructions)	1,321,219	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,071,893	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/17/2015 1:25 pm

Title XVIII | Skilled Nursing Facility | PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/17/2015 1:25 pm

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		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		6,988,490		30.00
31.00	03100	INTENSIVE CARE UNIT		1,578,289		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314663	2,365,837	744,441	50.00
53.00	05300	ANESTHESIOLOGY	0.047091	351,776	16,565	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239452	687,276	164,570	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.180252	143,816	25,923	55.00
57.00	05700	CT SCAN	0.041546	1,185,833	49,267	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052594	263,564	13,862	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.206789	1,493,617	308,864	59.00
60.00	06000	LABORATORY	0.298272	3,404,538	1,015,478	60.00
65.00	06500	RESPIRATORY THERAPY	0.158288	4,445,899	703,732	65.00
66.00	06600	PHYSICAL THERAPY	0.428501	778,170	333,447	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431998	2,162,826	934,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.414726	2,964,875	1,229,611	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376480	4,942,591	1,860,787	73.00
76.00	03020	CARDIAC REHAB	1.520109	15,669	23,819	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.901344	3,882	3,499	90.00
90.01	09001	WOUND CENTER	0.251161	37,888	9,516	90.01
91.00	09100	EMERGENCY	0.175790	2,779,314	488,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.634107	126,517	80,225	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		28,153,888	8,006,519	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)		28,153,888		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/17/2015 1:25 pm

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		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	0.314663	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.047091	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.239452	76,584	18,338	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.180252	0	0	55.00
57.00	05700	CT SCAN	0.041546	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.052594	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.206789	0	0	59.00
60.00	06000	LABORATORY	0.298272	96,700	28,843	60.00
65.00	06500	RESPIRATORY THERAPY	0.158288	56,369	8,923	65.00
66.00	06600	PHYSICAL THERAPY	0.428501	2,557,978	1,096,096	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.431998	12,093	5,224	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.414726	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.376480	435,070	163,795	73.00
76.00	03020	CARDIAC REHAB	1.520109	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.901344	0	0	90.00
90.01	09001	WOUND CENTER	0.251161	0	0	90.01
91.00	09100	EMERGENCY	0.175790	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.634107	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,234,794	1,321,219	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,234,794		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/17/2015 1:25 pm

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,904,886			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,462,938			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)		53,022			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		2,928,178			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		140.21			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	Adjusment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.01			30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.99			31.00
32.00	Sum of lines 30 and 31		27.00			32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.49			33.00
34.00	Disproportionate share adjustment (see instructions)		355,266			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		0	35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,024,336		691,722	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		258,189		517,370	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		775,559			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)		13,551,671			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0			48.00
49.00	Total payment for inpatient operating costs (see instructions)		13,551,671			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,049,294			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)		14,600,965			59.00
60.00	Primary payer payments		10,018			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,590,947			61.00
62.00	Deductibles billed to program beneficiaries		1,623,904			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/17/2015 1:25 pm

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		9,340			63.00
64.00	Allowable bad debts (see instructions)		245,780			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		159,757			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		215,413			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,117,460			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)		16,197			70.93
70.94	HRR adjustment amount (see instructions)		-108,097			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,025,560			71.00
71.01	Sequestration adjustment (see instructions)		260,511			71.01
72.00	Interim payments		12,637,299			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)		127,750			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/17/2015 1:25 pm

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		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		0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0		0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140275	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/17/2015 1:25 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,286	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,107,070	2.00
3.00	PPS payments	6,048,578	3.00
4.00	Outlier payment (see instructions)	14,134	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.274	5.00
6.00	Line 2 times line 5	1,673,337	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)	5,286	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	14,106	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	14,106	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	14,106	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	8,820	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)	5,286	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)	6,062,712	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)	1,267,658	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)	4,800,340	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)	4,800,340	30.00
31.00	Primary payer payments	1,936	31.00
32.00	Subtotal (line 30 minus line 31)	4,798,404	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)	209,603	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	136,242	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	155,170	36.00
37.00	Subtotal (see instructions)	4,934,646	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)	4,934,646	40.00
40.01	Sequestration adjustment (see instructions)	98,693	40.01
41.00	Interim payments	4,841,266	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-5,313	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: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2015 1:25 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12,637,299		4,841,266	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)		12,637,299		4,841,266	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		127,750		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		5,313	6.02
7.00	Total Medicare program liability (see instructions)		12,765,049		4,835,953	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: 140275 | Component CCN: 145703 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2015 1:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,006,862		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)		3,006,862		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)		3,006,862		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: 140275	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/17/2015 1:25 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	3,812	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	6,063	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,478	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	12,120	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	207,998,942	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,950,074	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)	401,544	8.00
9.00	Sequestration adjustment amount (see instructions)	8,031	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	393,513	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)	393,513	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 11/17/2015 1:25 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	3,523,358	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,523,358	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	455,131	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	3,068,227	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	3,068,227	15.00
15.01	Sequestration adjustment (see instructions)	61,365	15.01
16.00	Interim payments	3,006,862	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/17/2015 1:25 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	21,496,656	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	10,324,720	0	0	0	4.00
5.00	Other receivable	2,247,506	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,370,307	0	0	0	7.00
8.00	Prepaid expenses	399,182	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	36,838,371	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,374,122	0	0	0	12.00
13.00	Land improvements	4,952,083	0	0	0	13.00
14.00	Accumulated depreciation	-1,685,533	0	0	0	14.00
15.00	Buildings	60,242,158	0	0	0	15.00
16.00	Accumulated depreciation	-36,160,005	0	0	0	16.00
17.00	Leasehold improvements	2,090,593	0	0	0	17.00
18.00	Accumulated depreciation	-80,990	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	47,071,269	0	0	0	23.00
24.00	Accumulated depreciation	-38,258,198	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	40,545,499	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,183,816	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	15,018,023	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,201,839	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	94,585,709	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,960,521	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,381,602	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,635,948	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	7,370,415	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,348,486	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,879,659	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	631,918	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	9,511,577	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	23,860,063	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	70,725,646				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	70,725,646	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	94,585,709	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/17/2015 1:25 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		65,225,743		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,505,223				2.00
3.00	Total (sum of line 1 and line 2)		70,730,966		0		3.00
4.00	ADDITIONS	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		70,730,966		0		11.00
12.00	DEDUCTIONS	5,320		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,320		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		70,725,646		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140275 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/17/2015 1:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,278,288		14,278,288	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	6,963,174		6,963,174	7.00
8.00	NURSING FACILITY	1,448,060		1,448,060	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,689,522		22,689,522	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,152,364		3,152,364	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,152,364		3,152,364	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,841,886		25,841,886	17.00
18.00	Ancillary services	64,045,841	131,438,957	195,484,798	18.00
19.00	Outpatient services	0	0	0	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CROSSTOWN SQUARE	958,403	0	958,403	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	90,846,130	131,438,957	222,285,087	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		86,589,526		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	INCOME TAX	23,553			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)		23,553		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		86,565,973		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140275	Period: From 07/01/2014 To 06/30/2015	Worksheet G-3 Date/Time Prepared: 11/17/2015 1:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	222,285,087	1.00
2.00	Less contractual allowances and discounts on patients' accounts	134,684,823	2.00
3.00	Net patient revenues (line 1 minus line 2)	87,600,264	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	86,565,973	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,034,291	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	4,711,552	24.00
24.01	NONOPERATING GAINS & LOSSES	-240,620	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	4,470,932	25.00
26.00	Total (line 5 plus line 25)	5,505,223	26.00
27.00		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)	5,505,223	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140275	Period: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Prepared: 11/17/2015 1:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	985,895	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	7,992	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)	33.70	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)	3.01	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	23.99	8.00
9.00	Sum of lines 7 and 8	27.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.62	10.00
11.00	Disproportionate share adjustment (see instructions)	55,407	11.00
12.00	Total prospective capital payments (see instructions)	1,049,294	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