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: 141306	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/20/2015 1:07 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/20/2015 Time: 1:07 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 COMMUNITY MEMORIAL HOSPITAL (141306) 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	-14,556	-26,907	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	15,421	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	865	-26,907	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2015 12:57 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 CALDWELL STREET	PO Box:			1.00
2.00	City: STAUNTON	State: IL	Zip Code: 62088-1499	County: MACOUPIN	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	COMMUNITY MEMORIAL HOSPITAL	141306	99914	1	08/01/2000	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	COMMUNITY MEMORIAL HOSPITAL- SWB	14Z306	99914		08/01/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3		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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 12:57 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 12:57 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: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2015 12:57 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2015 12:57 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		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.	Y	Y	Y	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	108,496	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		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: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 12:57 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	164,104	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141306	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 12:57 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2015 12:57 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	09/22/2015	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: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/20/2015 12:57 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				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		BRIAN	ENGELKE		41.00
42.00	Enter the employer/company name of the cost report preparer.		COMMUNITY MEMORIAL HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		(618) 635-4242	BENGELKE@STAUNTONHOSPITAL.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2015 12:57 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)	09/22/2015			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.		CFO		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: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2015 12:57 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	25	9,125	13,056.00	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)		25	9,125	13,056.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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						13.00
14.00	Total (see instructions)		25	9,125	13,056.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	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)		25				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: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2015 12:57 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)	456	30	544			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	394	0	394			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	38			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	850	30	976			7.00
8.00	INTENSIVE CARE UNIT	0	0	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						13.00
14.00	Total (see instructions)	850	30	976	0.00	105.52	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	105.52	27.00
28.00	Observation Bed Days		16	115			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	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: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2015 12:57 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	139	12	183	1.00
2.00	HMO and other (see instructions)			0	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	139	12	183	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/20/2015 12:57 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)	0.470954	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,148,000	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?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	394,429	5.00
6.00	Medicaid charges	5,128,714	6.00
7.00	Medicaid cost (line 1 times line 6)	2,415,388	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	77,660	0	77,660	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	36,574	0	36,574	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)	36,574	0	36,574	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,016,622	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	193,474	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	823,148	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	387,665	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	424,239	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	424,239	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		486,602	486,602	-400,414	86,188	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1		0	0	12,779	12,779	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2		0	0	61,231	61,231	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	370,922	370,922	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	3,377	3,377	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,229,072	1,229,072	93,410	1,322,482	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	882,372	1,091,717	1,974,089	-716,251	1,257,838	5.01
5.02	00550	DATA PROCESSING	0	0	0	349,683	349,683	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	225,407	225,407	5.03
7.00	00700	OPERATION OF PLANT	173,630	381,070	554,700	828	555,528	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,980	33,584	41,564	0	41,564	8.00
9.00	00900	HOUSEKEEPING	162,600	18,877	181,477	0	181,477	9.00
10.00	01000	DIETARY	111,501	93,162	204,663	-103,828	100,835	10.00
11.00	01100	CAFETERIA	0	0	0	103,828	103,828	11.00
13.00	01300	NURSING ADMINISTRATION	219,354	11,193	230,547	0	230,547	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	143,466	53,914	197,380	0	197,380	16.00
17.00	01700	SOCIAL SERVICE	60,620	0	60,620	0	60,620	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	175,565	175,565	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	927,711	54,459	982,170	30,667	1,012,837	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	176,148	40,683	216,831	0	216,831	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	179,637	179,637	-175,565	4,072	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	424,699	544,395	969,094	0	969,094	54.00
60.00	06000	LABORATORY	432,054	419,562	851,616	0	851,616	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,029	1,029	0	1,029	64.00
65.00	06500	RESPIRATORY THERAPY	178,535	205,414	383,949	-26,874	357,075	65.00
66.00	06600	PHYSICAL THERAPY	44,212	604,820	649,032	6,466	655,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	50,201	50,201	0	50,201	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,108	9,108	0	9,108	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,987	101,510	189,497	26,874	216,371	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	193,781	879,327	1,073,108	0	1,073,108	73.00
76.00	03050	CARDIAC REHAB	65,021	10,671	75,692	0	75,692	76.00
76.01	03030	BEHAVIORAL HEALTH	127,003	119,624	246,627	0	246,627	76.01
76.02	03040	WOUND CARE	0	291,250	291,250	0	291,250	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,241	40,981	74,222	286,774	360,996	90.00
91.00	09100	EMERGENCY	428,183	1,463,475	1,891,658	0	1,891,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,907	1,907	-1,907	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,880,098	8,417,244	13,297,342	322,972	13,620,314	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	677,934	111,109	789,043	-322,972	466,071	192.00
194.00	07950	MOB	0	99,142	99,142	0	99,142	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	5,558,032	8,627,495	14,185,527	0	14,185,527	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-52,247	33,941		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	12,779		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	61,231		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-122,704	248,218		2.00
3.00	00300	OTHER CAP REL COSTS	-3,377	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,967	1,315,515		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-317,382	940,456		5.01
5.02	00550	DATA PROCESSING	0	349,683		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	225,407		5.03
7.00	00700	OPERATION OF PLANT	0	555,528		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	41,564		8.00
9.00	00900	HOUSEKEEPING	0	181,477		9.00
10.00	01000	DIETARY	-970	99,865		10.00
11.00	01100	CAFETERIA	-40,442	63,386		11.00
13.00	01300	NURSING ADMINISTRATION	-1,540	229,007		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,232	190,148		16.00
17.00	01700	SOCIAL SERVICE	0	60,620		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	175,565		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,012,837		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	216,831		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	4,072		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-851	968,243		54.00
60.00	06000	LABORATORY	-30,021	821,595		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,029		64.00
65.00	06500	RESPIRATORY THERAPY	-16,894	340,181		65.00
66.00	06600	PHYSICAL THERAPY	0	655,498		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	50,201		67.00
68.00	06800	SPEECH PATHOLOGY	0	9,108		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,503	214,868		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-6,095	1,067,013		73.00
76.00	03050	CARDIAC REHAB	-2,450	73,242		76.00
76.01	03030	BEHAVIORAL HEALTH	0	246,627		76.01
76.02	03040	WOUND CARE	0	291,250		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-215,258	145,738		90.00
91.00	09100	EMERGENCY	-509,037	1,382,621		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,334,970	12,285,344		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-18,808	447,263		192.00
194.00	07950	MOB	0	99,142		194.00
194.01	07951	MOB	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,353,778	12,831,749		200.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/20/2015 12:57 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	11,571		1.00
2.00	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	55,528		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	327,351		3.00
4.00	OPERATION OF PLANT	7.00	0	828		4.00
5.00	PHYSICAL THERAPY	66.00	0	6,466		5.00
	0		0	401,744		
	B - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35,099		1.00
	0		0	35,099		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,907		1.00
	0		0	1,907		
	D - EQUIPMENTAL RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	21,332		1.00
	0		0	21,332		
	E - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	56,565	47,263		1.00
	0		56,565	47,263		
	F - OXYGEN EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	26,874		1.00
	0		0	26,874		
	G - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	28,573		1.00
	0		0	28,573		
	H - ADVERTISING					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5,531		1.00
	0		0	5,531		
	I - ADMINISTRATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	57,269	1,042		1.00
2.00	DATA PROCESSING	5.02	148,892	200,791		2.00
3.00	BILLING, COLLECTION, & ADMITTING	5.03	161,187	64,220		3.00
	0		367,348	266,053		
	J - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	175,565		1.00
	0		0	175,565		
	K - PROPERTY TAX					
1.00	OTHER CAP REL COSTS	3.00	0	3,377		1.00
	0		0	3,377		
	L - MED DIR OF ONCOLOGY					
1.00	ADULTS & PEDIATRICS	30.00	0	30,667		1.00
	TOTALS		0	30,667		
	M - PROVIDER BASED CLINIC					
1.00	CLINIC	90.00	278,675	38,766		1.00
	TOTALS		278,675	38,766		
500.00	Grand Total: Increases		702,588	1,082,751		500.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/20/2015 12:57 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	401,744	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		0	401,744			
	B - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	35,099	0		1.00
	0		0	35,099			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,907	11		1.00
	0		0	1,907			
	D - EQUIPMENTAL RENTAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	21,332	10		1.00
	0		0	21,332			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	56,565	47,263	0		1.00
	0		56,565	47,263			
	F - OXYGEN EXPENSE						
1.00	RESPIRATORY THERAPY	65.00	0	26,874	0		1.00
	0		0	26,874			
	G - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	28,573	0		1.00
	0		0	28,573			
	H - ADVERTISING						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,531	12		1.00
	0		0	5,531			
	I - ADMINISTRATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	367,348	266,053	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		367,348	266,053			
	J - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	175,565	0		1.00
	0		0	175,565			
	K - PROPERTY TAX						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	3,377	0		1.00
	0		0	3,377			
	L - MED DIR OF ONCOLOGY						
1.00	CLINIC	90.00	0	30,667	0		1.00
	TOTALS		0	30,667			
	M - PROVIDER BASED CLINIC						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	278,675	38,766	0		1.00
	TOTALS		278,675	38,766			
500.00	Grand Total: Decreases		702,588	1,082,751			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2015 12:57 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	520,386	12,000	0	12,000	0	1.00
2.00	Land Improvements	508,275	23,327	0	23,327	4,055	2.00
3.00	Buildings and Fixtures	3,472,958	33,000	0	33,000	3,163	3.00
4.00	Building Improvements	2,468,539	0	0	0	462,949	4.00
5.00	Fixed Equipment	178,204	19,084	0	19,084	44,810	5.00
6.00	Movable Equipment	6,188,520	9,834,116	0	9,834,116	225,874	6.00
7.00	HIT designated Assets	333,261	164,104	0	164,104	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,670,143	10,085,631	0	10,085,631	740,851	8.00
9.00	Reconciling Items	2,014,105	9,563,961	0	9,563,961	0	9.00
10.00	Total (line 8 minus line 9)	11,656,038	521,670	0	521,670	740,851	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	532,386	0	1.00
2.00	Land Improvements	527,547	0	2.00
3.00	Buildings and Fixtures	3,502,795	0	3.00
4.00	Building Improvements	2,005,590	0	4.00
5.00	Fixed Equipment	152,478	0	5.00
6.00	Movable Equipment	15,796,762	0	6.00
7.00	HIT designated Assets	497,365	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,014,923	0	8.00
9.00	Reconciling Items	11,578,066	0	9.00
10.00	Total (line 8 minus line 9)	11,436,857	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 11/20/2015 12:57 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	486,602	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	486,602	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	486,602		1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0		1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	486,602		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/20/2015 12:57 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,059,933	0	1,059,933	0.046545	1,330	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	962,895	0	962,895	0.042284	1,208	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	4,545,490	0	4,545,490	0.199606	5,703	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	16,446,605	242,574	16,204,031	0.711565	20,332	2.00
3.00	Total (sum of lines 1-2)	23,014,923	242,574	22,772,349	1.000000	28,573	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1,330	32,611	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0	1,208	11,571	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	5,703	55,528	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	20,332	206,554	21,332	2.00
3.00	Total (sum of lines 1-2)	0	0	28,573	306,264	21,332	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,330	0	0	33,941	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	1,208	0	0	12,779	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	5,703	0	0	61,231	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	20,332	0	0	248,218	2.00
3.00	Total (sum of lines 1-2)	0	28,573	0	0	356,169	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/20/2015 12:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT- BLDG 1 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT- BLDG 2 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,907	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-18,808	PHYSICIANS' PRIVATE OFFICES	192.00	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)	B	-30,604	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-600	CLINIC	90.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,841	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,929	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-770,610			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-40,442	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,503	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-6,095	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,118	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT- BLDG 1		0	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT- BLDG 2		0	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/20/2015 12:57 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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-120,797	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	IHA LOBBYING FEES	A	-7,030	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	TAXES	A	-3,377	OTHER CAP REL COSTS	3.00	13	33.01
33.02	MEDICAID PROVIDER TAX	A	-230,035	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.02
33.03	TRANSCRIPTION SERVICCE	B	-114	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	MISCELLANEOUS OPERATING REVENUE	B	-3,933	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.04
33.05	X-RAY FILM COPYING	B	-851	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	INSERVICE EDUCATION	B	-1,540	NURSING ADMINISTRATION	13.00	0	33.06
33.07	CARDIAC REHAB	B	-2,450	CARDIAC REHAB	76.00	0	33.07
33.08	DIABETIC CONSULTATION	B	-970	DIETARY	10.00	0	33.08
33.09	PUBLIC RELATIONS SALARIES	A	-28,697	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.09
33.10	PUBLIC REATIONS OTHER	A	-2,782	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.10
33.11	PUBLIC RELATIONS BENEFITS	A	-6,967	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PHYSICIAN ADVERTISING EXPENSE	A	-5,531	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.12
33.13	ACCELERATED DEPRECIATION	A	-52,247	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,353,778				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2015 12:57 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	30.00	ADULTS & PEDIATRICS	30,667	0	30,667	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	16,894	16,894	0	0	0	2.00
3.00	90.00	CLINIC	214,658	214,658	0	0	0	3.00
4.00	91.00	EMERGENCY	1,389,943	509,037	880,906	0	0	4.00
5.00	76.01	BEHAVIORAL HEALTH	28,375	0	28,375	0	0	5.00
6.00	60.00	LABORATORY	82,029	30,021	52,008	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,762,566	770,610	991,956		0	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	76.01	BEHAVIORAL HEALTH	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	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	30.00	ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	16,894		2.00
3.00	90.00	CLINIC	0	0	0	214,658		3.00
4.00	91.00	EMERGENCY	0	0	0	509,037		4.00
5.00	76.01	BEHAVIORAL HEALTH	0	0	0	0		5.00
6.00	60.00	LABORATORY	0	0	0	30,021		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	770,610		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/20/2015 12:57 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					255	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,858.00	1,917.00	5,370.50	275.00	0.00	9.00
10.00	AHSEA (see instructions)	104.11	77.12	57.84	38.56	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.56	38.56	28.92			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					193,436	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					147,839	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					310,630	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					651,905	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					10,604	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					662,509	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					662,509	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					9,833	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,833	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,594	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,427	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,427	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/20/2015 12:57 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.12	57.84	38.56	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	662,509		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	11,427		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	673,936		63.00
64.00	Total cost of outside supplier services (from your records)	586,530		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	9,833		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,594		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	11,427		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,594		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,594		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/20/2015 12:57 pm

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	134	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	113	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	6.25	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	308.00	605.25	0.00	0.00	9.00
10.00	AHSEA (see instructions)	98.68	73.10	54.82	36.55	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.55	36.55	27.41			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	22,515	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	33,180	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	55,695	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	55,695	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	55,695	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	4,898	24.00
25.00	Assistants (line 4 times column 3, line 11)	3,097	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	7,995	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,544	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	9,539	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	9,539	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/20/2015 12:57 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.10	54.82	36.55	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	55,695	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	9,539	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	65,234	63.00
64.00	Total cost of outside supplier services (from your records)	50,201	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,995	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,544	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	9,539	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,544	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,544	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/20/2015 12:57 pm

Speech Pathology | Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						58	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						6.25	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	126.00	0.00	0.00	0.00		9.00
10.00	AHSEA (see instructions)	94.83	70.24	52.68	35.12	0.00		10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.12	35.12	26.34				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						8,850	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						8,850	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						8,850	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						70.24	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						54,787	22.00
23.00	Total salary equivalency (see instructions)						54,787	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						2,037	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						2,037	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						363	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						2,400	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						2,400	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/20/2015 12:57 pm

		Speech Pathology	Cost	
		1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0		46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	70.24	52.68	35.12	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	54,787	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	2,400	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	57,187	63.00
64.00	Total cost of outside supplier services (from your records)	9,108	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	2,037	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	363	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	2,400	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	363	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	363	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT- BLDG 1	BLDG & FIXT- BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	33,941	33,941				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	12,779	0	12,779			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2	61,231	0	0	61,231		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	248,218				248,218	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,315,515	0	0	0	0	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	940,456	4,231	3,703	2,318	29,938	5.01
5.02	00550	DATA PROCESSING	349,683	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	225,407	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	555,528	7,684	3,724	12,251	54,845	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,564	665	718	0	4,744	8.00
9.00	00900	HOUSEKEEPING	181,477	594	235	1,088	4,236	9.00
10.00	01000	DIETARY	99,865	845	0	2,443	6,029	10.00
11.00	01100	CAFETERIA	63,386	596	0	1,722	4,251	11.00
13.00	01300	NURSING ADMINISTRATION	229,007	329	0	953	2,351	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	190,148	618	80	1,570	4,407	16.00
17.00	01700	SOCIAL SERVICE	60,620	132	0	383	945	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	175,565	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,012,837	5,455	0	15,773	38,927	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	216,831	2,109	0	6,098	15,050	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,072	46	0	132	325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	968,243	2,338	0	6,760	16,684	54.00
60.00	06000	LABORATORY	821,595	869	939	0	6,203	60.00
64.00	06400	INTRAVENOUS THERAPY	1,029	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	340,181	602	0	1,740	4,295	65.00
66.00	06600	PHYSICAL THERAPY	655,498	0	0	0	9,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,201	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,108	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,868	755	815	0	5,388	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,067,013	315	0	910	2,245	73.00
76.00	03050	CARDIAC REHAB	73,242	827	0	2,393	5,905	76.00
76.01	03030	BEHAVIORAL HEALTH	246,627	1,383	1,493	0	9,866	76.01
76.02	03040	WOUND CARE	291,250	745	805	0	5,317	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	145,738	1,493	0	1,623	10,032	90.00
91.00	09100	EMERGENCY	1,382,621	950	0	2,748	6,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,285,344	33,581	12,512	60,905	248,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	113	0	326	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	447,263	241	261	0	0	192.00
194.00	07950	MOB	99,142	6	6	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	12,831,749	33,941	12,779	61,231	248,218	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	DATA PROCESSING	
			4.00	4A	5.01	5A.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,315,515					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	116,916	1,097,562	1,097,562			5.01
5.02	00550	DATA PROCESSING	35,795	385,478	36,056	421,534	421,534	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	38,750	264,157	24,708	288,865	9,812	5.03
7.00	00700	OPERATION OF PLANT	41,742	675,774	63,209	738,983	25,101	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,918	49,609	4,640	54,249	1,843	8.00
9.00	00900	HOUSEKEEPING	39,090	226,720	21,206	247,926	8,421	9.00
10.00	01000	DIETARY	13,207	122,389	11,448	133,837	4,546	10.00
11.00	01100	CAFETERIA	13,599	83,554	7,815	91,369	3,104	11.00
13.00	01300	NURSING ADMINISTRATION	52,734	285,374	26,692	312,066	10,600	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,490	231,313	21,636	252,949	8,592	16.00
17.00	01700	SOCIAL SERVICE	14,573	76,653	7,170	83,823	2,847	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	175,565	16,421	191,986	6,521	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	223,026	1,296,018	121,223	1,417,241	48,139	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,347	282,435	26,418	308,853	10,491	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4,575	428	5,003	170	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,100	1,096,125	102,526	1,198,651	40,715	54.00
60.00	06000	LABORATORY	103,868	933,474	87,312	1,020,786	34,673	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,029	96	1,125	38	64.00
65.00	06500	RESPIRATORY THERAPY	42,921	389,739	36,454	426,193	14,476	65.00
66.00	06600	PHYSICAL THERAPY	10,629	675,580	63,190	738,770	25,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	50,201	4,696	54,897	1,865	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,108	852	9,960	338	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,153	242,979	22,727	265,706	9,025	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,586	1,117,069	104,485	1,221,554	41,493	73.00
76.00	03050	CARDIAC REHAB	15,631	97,998	9,166	107,164	3,640	76.00
76.01	03030	BEHAVIORAL HEALTH	30,532	289,901	27,116	317,017	10,768	76.01
76.02	03040	WOUND CARE	0	298,117	27,884	326,001	11,073	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	74,986	233,872	21,875	255,747	8,687	90.00
91.00	09100	EMERGENCY	102,938	1,496,039	139,938	1,635,977	55,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,219,531	12,188,407	1,037,387	12,128,232	397,637	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	95,984	96,423	9,019	105,442	3,582	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	447,765	41,882	489,647	16,632	192.00
194.00	07950	MOB	0	99,154	9,274	108,428	3,683	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,315,515	12,831,749	1,097,562	12,831,749	421,534	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	298,677					5.03
7.00	00700	OPERATION OF PLANT	0	764,084				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,836	77,928			8.00
9.00	00900	HOUSEKEEPING	0	19,497	0	275,844		9.00
10.00	01000	DIETARY	0	27,751	0	10,712	176,846	10.00
11.00	01100	CAFETERIA	0	19,565	0	7,552	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,823	0	4,178	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,286	0	7,830	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,351	0	1,679	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,659	179,176	77,928	69,159	176,846	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,512	69,274	0	26,739	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	2,343	1,496	0	577	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,172	76,793	0	29,642	0	54.00
60.00	06000	LABORATORY	78,373	28,553	0	11,021	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,495	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,547	19,769	0	7,631	0	65.00
66.00	06600	PHYSICAL THERAPY	29,858	43,509	0	16,794	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,956	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	153	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,785	24,800	0	9,573	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,199	10,333	0	3,989	0	73.00
76.00	03050	CARDIAC REHAB	1,196	27,179	0	10,491	0	76.00
76.01	03030	BEHAVIORAL HEALTH	5,812	45,412	0	17,529	0	76.01
76.02	03040	WOUND CARE	6,921	24,474	0	9,447	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,943	46,174	0	17,823	0	90.00
91.00	09100	EMERGENCY	16,753	31,218	0	12,050	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	298,677	752,269	77,928	274,416	176,846	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,698	0	1,428	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,927	0	0	0	192.00
194.00	07950	MOB	0	190	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	298,677	764,084	77,928	275,844	176,846	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	121,590					11.00
13.00	01300	NURSING ADMINISTRATION	7,530	345,197				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,925	0	294,582			16.00
17.00	01700	SOCIAL SERVICE	2,081	0	0	94,781		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	198,507	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,845	182,054	11,510	94,781	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,047	34,567	4,195	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	2,313	0	198,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,579	0	82,096	0	0	54.00
60.00	06000	LABORATORY	14,832	0	77,368	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	1,476	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,129	0	20,284	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,518	0	29,475	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,931	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	151	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,020	0	3,737	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,652	38,027	26,850	0	0	73.00
76.00	03050	CARDIAC REHAB	2,232	0	1,181	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	4,360	0	5,738	0	0	76.01
76.02	03040	WOUND CARE	0	0	6,833	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,141	6,523	2,906	0	0	90.00
91.00	09100	EMERGENCY	14,699	84,026	16,538	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	121,590	345,197	294,582	94,781	198,507	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	121,590	345,197	294,582	94,781	198,507	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,300,338	0	2,300,338		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	464,678	0	464,678		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	210,409	0	210,409		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,525,648	0	1,525,648		54.00
60.00	06000	LABORATORY	1,265,606	0	1,265,606		60.00
64.00	06400	INTRAVENOUS THERAPY	4,134	0	4,134		64.00
65.00	06500	RESPIRATORY THERAPY	515,029	0	515,029		65.00
66.00	06600	PHYSICAL THERAPY	885,018	0	885,018		66.00
67.00	06700	OCCUPATIONAL THERAPY	60,649	0	60,649		67.00
68.00	06800	SPEECH PATHOLOGY	10,602	0	10,602		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	319,646	0	319,646		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,376,097	0	1,376,097		73.00
76.00	03050	CARDIAC REHAB	153,083	0	153,083		76.00
76.01	03030	BEHAVIORAL HEALTH	406,636	0	406,636		76.01
76.02	03040	WOUND CARE	384,749	0	384,749		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	341,944	0	341,944		90.00
91.00	09100	EMERGENCY	1,866,826	0	1,866,826		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,091,092	0	12,091,092		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	114,150	0	114,150		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	514,206	0	514,206		192.00
194.00	07950	MOB	112,301	0	112,301		194.00
194.01	07951	MOB	0	0	0		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	12,831,749	0	12,831,749		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT-BLDG 1	BLDG & FIXT-BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	4,231	3,703	2,318	29,938	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	7,684	3,724	12,251	54,845	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	665	718	0	4,744	8.00
9.00	00900	HOUSEKEEPING	0	594	235	1,088	4,236	9.00
10.00	01000	DIETARY	0	845	0	2,443	6,029	10.00
11.00	01100	CAFETERIA	0	596	0	1,722	4,251	11.00
13.00	01300	NURSING ADMINISTRATION	0	329	0	953	2,351	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	618	80	1,570	4,407	16.00
17.00	01700	SOCIAL SERVICE	0	132	0	383	945	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,455	0	15,773	38,927	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,109	0	6,098	15,050	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	46	0	132	325	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,338	0	6,760	16,684	54.00
60.00	06000	LABORATORY	0	869	939	0	6,203	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	602	0	1,740	4,295	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	9,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	755	815	0	5,388	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	315	0	910	2,245	73.00
76.00	03050	CARDIAC REHAB	0	827	0	2,393	5,905	76.00
76.01	03030	BEHAVIORAL HEALTH	0	1,383	1,493	0	9,866	76.01
76.02	03040	WOUND CARE	0	745	805	0	5,317	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,493	0	1,623	10,032	90.00
91.00	09100	EMERGENCY	0	950	0	2,748	6,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	33,581	12,512	60,905	248,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	113	0	326	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	241	261	0	0	192.00
194.00	07950	MOB	0	6	6	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	0	33,941	12,779	61,231	248,218	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	OTHER ADMINISTRATIVE AND GENERAL	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	
			2A	4.00	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	40,190	0	40,190			5.01
5.02	00550	DATA PROCESSING	0	0	1,320	1,320		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	905	31	936	5.03
7.00	00700	OPERATION OF PLANT	78,504	0	2,315	78	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,127	0	170	6	0	8.00
9.00	00900	HOUSEKEEPING	6,153	0	777	26	0	9.00
10.00	01000	DIETARY	9,317	0	419	14	0	10.00
11.00	01100	CAFETERIA	6,569	0	286	10	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,633	0	977	33	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,675	0	792	27	0	16.00
17.00	01700	SOCIAL SERVICE	1,460	0	263	9	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	601	20	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,155	0	4,439	150	36	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,257	0	967	33	14	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	503	0	16	1	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,782	0	3,754	127	269	54.00
60.00	06000	LABORATORY	8,011	0	3,197	108	243	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	4	0	5	64.00
65.00	06500	RESPIRATORY THERAPY	6,637	0	1,335	45	64	65.00
66.00	06600	PHYSICAL THERAPY	9,453	0	2,314	78	92	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	172	6	6	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	31	1	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,958	0	832	28	12	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,470	0	3,826	129	84	73.00
76.00	03050	CARDIAC REHAB	9,125	0	336	11	4	76.00
76.01	03030	BEHAVIORAL HEALTH	12,742	0	993	34	18	76.01
76.02	03040	WOUND CARE	6,867	0	1,021	35	21	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,148	0	801	27	9	90.00
91.00	09100	EMERGENCY	10,480	0	5,123	179	52	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	355,216	0	37,986	1,246	936	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	439	0	330	11	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	502	0	1,534	52	0	192.00
194.00	07950	MOB	12	0	340	11	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	356,169	0	40,190	1,320	936	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	80,897					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,312	8,615				8.00
9.00	00900	HOUSEKEEPING	2,064	0	9,020			9.00
10.00	01000	DIETARY	2,938	0	350	13,038		10.00
11.00	01100	CAFETERIA	2,071	0	247	0	9,183	11.00
13.00	01300	NURSING ADMINISTRATION	1,146	0	137	0	569	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,148	0	256	0	372	16.00
17.00	01700	SOCIAL SERVICE	461	0	55	0	157	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,971	8,615	2,262	13,038	2,405	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,334	0	874	0	457	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	158	0	19	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,130	0	969	0	1,101	54.00
60.00	06000	LABORATORY	3,023	0	360	0	1,120	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,093	0	250	0	463	65.00
66.00	06600	PHYSICAL THERAPY	4,606	0	549	0	115	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,626	0	313	0	228	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,094	0	130	0	502	73.00
76.00	03050	CARDIAC REHAB	2,878	0	343	0	169	76.00
76.01	03030	BEHAVIORAL HEALTH	4,808	0	573	0	329	76.01
76.02	03040	WOUND CARE	2,591	0	309	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,889	0	583	0	86	90.00
91.00	09100	EMERGENCY	3,305	0	394	0	1,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	79,646	8,615	8,973	13,038	9,183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	392	0	47	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	839	0	0	0	0	192.00
194.00	07950	MOB	20	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	80,897	8,615	9,020	13,038	9,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	6,495					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,270				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,405			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	621		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,426	401	2,405		116,303	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	650	146	0		33,732	50.00
51.00	05100	RECOVERY ROOM	0	0	0		0	51.00
53.00	05300	ANESTHESIOLOGY	0	81	0		785	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,864	0		42,996	54.00
60.00	06000	LABORATORY	0	2,697	0		18,759	60.00
64.00	06400	INTRAVENOUS THERAPY	0	51	0		60	64.00
65.00	06500	RESPIRATORY THERAPY	0	707	0		11,594	65.00
66.00	06600	PHYSICAL THERAPY	0	1,028	0		18,235	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67	0		251	67.00
68.00	06800	SPEECH PATHOLOGY	0	5	0		37	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	130	0		11,127	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	715	936	0		10,886	73.00
76.00	03050	CARDIAC REHAB	0	41	0		12,907	76.00
76.01	03030	BEHAVIORAL HEALTH	0	200	0		19,697	76.01
76.02	03040	WOUND CARE	0	238	0		11,082	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	123	101	0		19,767	90.00
91.00	09100	EMERGENCY	1,581	577	0		22,801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,495	10,270	2,405	0	351,019	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		1,219	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		2,927	192.00
194.00	07950	MOB	0	0	0		383	194.00
194.01	07951	MOB	0	0	0		0	194.01
200.00		Cross Foot Adjustments				621	621	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,495	10,270	2,405	621	356,169	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING				5.03
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	116,303		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	33,732		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	785		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,996		54.00
60.00	06000	LABORATORY	0	18,759		60.00
64.00	06400	INTRAVENOUS THERAPY	0	60		64.00
65.00	06500	RESPIRATORY THERAPY	0	11,594		65.00
66.00	06600	PHYSICAL THERAPY	0	18,235		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	251		67.00
68.00	06800	SPEECH PATHOLOGY	0	37		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,127		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,886		73.00
76.00	03050	CARDIAC REHAB	0	12,907		76.00
76.01	03030	BEHAVIORAL HEALTH	0	19,697		76.01
76.02	03040	WOUND CARE	0	11,082		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	19,767		90.00
91.00	09100	EMERGENCY	0	22,801		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	351,019		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,219		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,927		192.00
194.00	07950	MOB	0	383		194.00
194.01	07951	MOB	0	0		194.01
200.00		Cross Foot Adjustments	0	621		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	356,169		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-BLDG 1 (SQUARE FEET)	BLDG & FIXT-BLDG 2 (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	81,995					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	28,586				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	51,158			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				84,029		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	5,472,066	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	10,221	8,284	1,937	10,135	486,327	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	148,892	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	161,187	5.03
7.00	00700	OPERATION OF PLANT	18,566	8,330	10,236	18,566	173,630	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,606	1,606	0	1,606	7,980	8.00
9.00	00900	HOUSEKEEPING	1,434	525	909	1,434	162,600	9.00
10.00	01000	DIETARY	2,041	0	2,041	2,041	54,936	10.00
11.00	01100	CAFETERIA	1,439	0	1,439	1,439	56,565	11.00
13.00	01300	NURSING ADMINISTRATION	796	0	796	796	219,354	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492	180	1,312	1,492	143,466	16.00
17.00	01700	SOCIAL SERVICE	320	0	320	320	60,620	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,178	0	13,178	13,178	927,711	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,095	0	5,095	5,095	176,148	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	110	0	110	110	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,648	0	5,648	5,648	424,699	54.00
60.00	06000	LABORATORY	2,100	2,100	0	2,100	432,054	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,454	0	1,454	1,454	178,535	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,200	44,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,824	1,824	0	1,824	87,987	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	0	760	760	193,781	73.00
76.00	03050	CARDIAC REHAB	1,999	0	1,999	1,999	65,021	76.00
76.01	03030	BEHAVIORAL HEALTH	3,340	3,340	0	3,340	127,003	76.01
76.02	03040	WOUND CARE	1,800	1,800	0	1,800	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,607	0	1,356	3,396	311,916	90.00
91.00	09100	EMERGENCY	2,296	0	2,296	2,296	428,183	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	81,126	27,989	50,886	84,029	5,072,807	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	272	0	272	0	399,259	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	583	583	0	0	0	192.00
194.00	07950	MOB	14	14	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	33,941	12,779	61,231	248,218	1,315,515	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.413940	0.447037	1.196900	2.953956	0.240406	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	DATA PROCESSING (ACCUM. COST)	BILLING, COLLECTION, & ADMITTING (GROSS CHARGES)	
			5A.01	5.01	5A.02	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-1,097,562	11,734,187				5.01
5.02	00550	DATA PROCESSING	0	385,478	-421,534	12,410,215		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	264,157	0	288,865	25,696,228	5.03
7.00	00700	OPERATION OF PLANT	0	675,774	0	738,983	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,609	0	54,249	0	8.00
9.00	00900	HOUSEKEEPING	0	226,720	0	247,926	0	9.00
10.00	01000	DIETARY	0	122,389	0	133,837	0	10.00
11.00	01100	CAFETERIA	0	83,554	0	91,369	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	285,374	0	312,066	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	231,313	0	252,949	0	16.00
17.00	01700	SOCIAL SERVICE	0	76,653	0	83,823	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	175,565	0	191,986	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,296,018	0	1,417,241	1,003,094	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	282,435	0	308,853	388,205	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4,575	0	5,003	201,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,096,125	0	1,198,651	7,154,877	54.00
60.00	06000	LABORATORY	0	933,474	0	1,020,786	6,742,923	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,029	0	1,125	128,660	64.00
65.00	06500	RESPIRATORY THERAPY	0	389,739	0	426,193	1,767,819	65.00
66.00	06600	PHYSICAL THERAPY	0	675,580	0	738,770	2,568,853	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	50,201	0	54,897	168,280	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,108	0	9,960	13,142	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	242,979	0	265,706	325,677	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,117,069	0	1,221,554	2,340,070	73.00
76.00	03050	CARDIAC REHAB	0	97,998	0	107,164	102,926	76.00
76.01	03030	BEHAVIORAL HEALTH	0	289,901	0	317,017	500,075	76.01
76.02	03040	WOUND CARE	0	298,117	0	326,001	595,493	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	233,872	0	255,747	253,229	90.00
91.00	09100	EMERGENCY	0	1,496,039	0	1,635,977	1,441,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,097,562	11,090,845	-421,534	11,706,698	25,696,228	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	96,423	0	105,442	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	447,765	0	489,647	0	192.00
194.00	07950	MOB	0	99,154	0	108,428	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		1,097,562		421,534	298,677	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.093535		0.033967	0.011623	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		40,190		1,320	936	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003425		0.000106	0.000036	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	56,197					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,606	1,090				8.00
9.00	00900	HOUSEKEEPING	1,434	0	52,560			9.00
10.00	01000	DIETARY	2,041	0	2,041	1,090		10.00
11.00	01100	CAFETERIA	1,439	0	1,439	0	3,542,015	11.00
13.00	01300	NURSING ADMINISTRATION	796	0	796	0	219,354	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492	0	1,492	0	143,466	16.00
17.00	01700	SOCIAL SERVICE	320	0	320	0	60,620	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,178	1,090	13,178	1,090	927,711	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,095	0	5,095	0	176,148	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	110	0	110	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,648	0	5,648	0	424,699	54.00
60.00	06000	LABORATORY	2,100	0	2,100	0	432,054	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,454	0	1,454	0	178,535	65.00
66.00	06600	PHYSICAL THERAPY	3,200	0	3,200	0	44,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,824	0	1,824	0	87,987	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	0	760	0	193,781	73.00
76.00	03050	CARDIAC REHAB	1,999	0	1,999	0	65,021	76.00
76.01	03030	BEHAVIORAL HEALTH	3,340	0	3,340	0	127,003	76.01
76.02	03040	WOUND CARE	1,800	0	1,800	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,396	0	3,396	0	33,241	90.00
91.00	09100	EMERGENCY	2,296	0	2,296	0	428,183	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,328	1,090	52,288	1,090	3,542,015	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	272	0	272	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	583	0	0	0	0	192.00
194.00	07950	MOB	14	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	764,084	77,928	275,844	176,846	121,590	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.596527	71.493578	5.248174	162.244037	0.034328	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	80,897	8,615	9,020	13,038	9,183	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.439525	7.903670	0.171613	11.961468	0.002593	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 12:57 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,759,064					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,673,630				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,090			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	927,711	1,003,094	1,090	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	176,148	365,607	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	201,570	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,154,877	0	0		54.00
60.00	06000	LABORATORY	0	6,742,923	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	128,660	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,767,819	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,568,853	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	168,280	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	13,142	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	325,677	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	193,781	2,340,070	0	0		73.00
76.00	03050	CARDIAC REHAB	0	102,926	0	0		76.00
76.01	03030	BEHAVIORAL HEALTH	0	500,075	0	0		76.01
76.02	03040	WOUND CARE	0	595,493	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,241	253,229	0	0		90.00
91.00	09100	EMERGENCY	428,183	1,441,335	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,759,064	25,673,630	1,090	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	MOB	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
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)	345,197	294,582	94,781	198,507		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.196239	0.011474	86.955046	1,985.070000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,495	10,270	2,405	621		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003692	0.000400	2.206422	6.210000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | 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	2,300,338		2,300,338	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	464,678		464,678	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	210,409		210,409	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,525,648		1,525,648	0	0	54.00
60.00	06000	LABORATORY	1,265,606		1,265,606	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,134		4,134	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	515,029	0	515,029	0	0	65.00
66.00	06600	PHYSICAL THERAPY	885,018	0	885,018	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	60,649	0	60,649	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,602	0	10,602	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	319,646		319,646	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,376,097		1,376,097	0	0	73.00
76.00	03050	CARDIAC REHAB	153,083		153,083	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	406,636		406,636	0	0	76.01
76.02	03040	WOUND CARE	384,749		384,749	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	341,944		341,944	0	0	90.00
91.00	09100	EMERGENCY	1,866,826		1,866,826	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	250,676		250,676		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,341,768	0	12,341,768	0	0	200.00
201.00		Less Observation Beds	250,676		250,676		0	201.00
202.00		Total (see instructions)	12,091,092	0	12,091,092	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | 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	608,980		608,980			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,590	364,017	365,607	1.270977	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,210	200,360	201,570	1.043851	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,480	7,015,397	7,154,877	0.213232	0.000000	54.00
60.00	06000	LABORATORY	345,693	6,397,230	6,742,923	0.187694	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	36,062	92,598	128,660	0.032131	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	214,014	1,553,805	1,767,819	0.291336	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	179,505	2,389,348	2,568,853	0.344519	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	87,925	80,355	168,280	0.360405	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	4,150	8,992	13,142	0.806727	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	94,155	231,522	325,677	0.981482	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,209	2,176,861	2,340,070	0.588058	0.000000	73.00
76.00	03050	CARDIAC REHAB	3,858	99,068	102,926	1.487311	0.000000	76.00
76.01	03030	BEHAVIORAL HEALTH	0	500,075	500,075	0.813150	0.000000	76.01
76.02	03040	WOUND CARE	0	595,493	595,493	0.646102	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	253,229	253,229	1.350335	0.000000	90.00
91.00	09100	EMERGENCY	5,190	1,436,145	1,441,335	1.295206	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	394,114	394,114	0.636049	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,885,021	23,788,609	25,673,630			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,885,021	23,788,609	25,673,630			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03050	CARDIAC REHAB	0.000000	76.00
76.01	03030	BEHAVIORAL HEALTH	0.000000	76.01
76.02	03040	WOUND CARE	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		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 ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		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	33,732	365,607	0.092263	1,560	144	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	785	201,570	0.003894	1,210	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,996	7,154,877	0.006009	86,949	522	54.00
60.00	06000	LABORATORY	18,759	6,742,923	0.002782	233,487	650	60.00
64.00	06400	INTRAVENOUS THERAPY	60	128,660	0.000466	25,943	12	64.00
65.00	06500	RESPIRATORY THERAPY	11,594	1,767,819	0.006558	154,305	1,012	65.00
66.00	06600	PHYSICAL THERAPY	18,235	2,568,853	0.007098	39,620	281	66.00
67.00	06700	OCCUPATIONAL THERAPY	251	168,280	0.001492	13,625	20	67.00
68.00	06800	SPEECH PATHOLOGY	37	13,142	0.002815	654	2	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,127	325,677	0.034166	62,762	2,144	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,886	2,340,070	0.004652	91,388	425	73.00
76.00	03050	CARDIAC REHAB	12,907	102,926	0.125401	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	19,697	500,075	0.039388	0	0	76.01
76.02	03040	WOUND CARE	11,082	595,493	0.018610	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,767	253,229	0.078060	0	0	90.00
91.00	09100	EMERGENCY	22,801	1,441,335	0.015819	4,150	66	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	20,296	394,114	0.051498	0	0	92.00
200.00		Total (lines 50-199)	255,012	25,064,650		715,653	5,283	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	198,507	0	0	0	198,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03050	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	0	0	0	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	198,507	0	0	0	198,507	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		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	365,607	0.000000	0.000000	1,560	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	201,570	0.984804	0.000000	1,210	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,154,877	0.000000	0.000000	86,949	54.00
60.00	06000	LABORATORY	0	6,742,923	0.000000	0.000000	233,487	60.00
64.00	06400	INTRAVENOUS THERAPY	0	128,660	0.000000	0.000000	25,943	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,767,819	0.000000	0.000000	154,305	65.00
66.00	06600	PHYSICAL THERAPY	0	2,568,853	0.000000	0.000000	39,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	168,280	0.000000	0.000000	13,625	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,142	0.000000	0.000000	654	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	325,677	0.000000	0.000000	62,762	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,340,070	0.000000	0.000000	91,388	73.00
76.00	03050	CARDIAC REHAB	0	102,926	0.000000	0.000000	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	500,075	0.000000	0.000000	0	76.01
76.02	03040	WOUND CARE	0	595,493	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	253,229	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,441,335	0.000000	0.000000	4,150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	394,114	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	25,064,650			715,653	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	1,192	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03050	CARDIAC REHAB	0	0	0		76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	0		76.01
76.02	03040	WOUND CARE	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	1,192	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		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	1.270977	0	186,142	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.043851	0	94,930	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213232	0	2,735,231	0	0	54.00
60.00	06000	LABORATORY	0.187694	0	2,956,903	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.032131	0	43,436	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.291336	0	664,609	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.344519	0	807,835	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.360405	0	17,835	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.806727	0	2,469	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.981482	0	108,553	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.588058	0	1,131,195	0	0	73.00
76.00	03050	CARDIAC REHAB	1.487311	0	81,488	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.813150	0	488,715	0	0	76.01
76.02	03040	WOUND CARE	0.646102	0	336,146	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.350335	0	68,206	0	0	90.00
91.00	09100	EMERGENCY	1.295206	0	457,885	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.636049	0	244,019	0	0	92.00
200.00		Subtotal (see instructions)		0	10,425,597	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	10,425,597	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		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	236,582	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	99,093	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	583,239	0		54.00
60.00	06000	LABORATORY	554,993	0		60.00
64.00	06400	INTRAVENOUS THERAPY	1,396	0		64.00
65.00	06500	RESPIRATORY THERAPY	193,625	0		65.00
66.00	06600	PHYSICAL THERAPY	278,315	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,428	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,992	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,543	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	665,208	0		73.00
76.00	03050	CARDIAC REHAB	121,198	0		76.00
76.01	03030	BEHAVIORAL HEALTH	397,399	0		76.01
76.02	03040	WOUND CARE	217,185	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	92,101	0		90.00
91.00	09100	EMERGENCY	593,055	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	155,208	0		92.00
200.00		Subtotal (see instructions)	4,303,560	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,303,560	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Swing Beds - SNF | Cost

		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	1.270977	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.043851	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213232	0	0	0	0	54.00
60.00	06000	LABORATORY	0.187694	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.032131	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.291336	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.344519	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.360405	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.806727	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.981482	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.588058	0	0	0	0	73.00
76.00	03050	CARDIAC REHAB	1.487311	0	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.813150	0	0	0	0	76.01
76.02	03040	WOUND CARE	0.646102	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.350335	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.295206	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.636049	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03050	CARDIAC REHAB	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	76.01
76.02	03040	WOUND CARE	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,091	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	659	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)	544	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	197	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)	197	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	23	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)	15	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	456	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)	197	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)	197	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.03	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.03	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,300,338	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	3,037	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)	1,980	25.00
26.00	Total swing-bed cost (see instructions)	863,854	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,436,484	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)	1,436,484	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)	2,179.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	993,984	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)	993,984	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	251,204	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,245,188	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	429,419	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	429,419	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	858,838	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)	115	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,179.79	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	250,676	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	116,303	1,436,484	0.080964	250,676	20,296	90.00
91.00	Nursing School cost	0	1,436,484	0.000000	250,676	0	91.00
92.00	Allied health cost	0	1,436,484	0.000000	250,676	0	92.00
93.00	All other Medical Education	0	1,436,484	0.000000	250,676	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		354,676		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.270977	1,560	1,983	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.043851	1,210	1,263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213232	86,949	18,540	54.00
60.00	06000	LABORATORY	0.187694	233,487	43,824	60.00
64.00	06400	INTRAVENOUS THERAPY	0.032131	25,943	834	64.00
65.00	06500	RESPIRATORY THERAPY	0.291336	154,305	44,955	65.00
66.00	06600	PHYSICAL THERAPY	0.344519	39,620	13,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.360405	13,625	4,911	67.00
68.00	06800	SPEECH PATHOLOGY	0.806727	654	528	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.981482	62,762	61,600	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.588058	91,388	53,741	73.00
76.00	03050	CARDIAC REHAB	1.487311	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.813150	0	0	76.01
76.02	03040	WOUND CARE	0.646102	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.350335	0	0	90.00
91.00	09100	EMERGENCY	1.295206	4,150	5,375	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.636049	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		715,653	251,204	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)		715,653		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3

Component CCN: 14Z306 | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.270977	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.043851	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213232	11,645	2,483	54.00
60.00	06000	LABORATORY	0.187694	64,189	12,048	60.00
64.00	06400	INTRAVENOUS THERAPY	0.032131	2,912	94	64.00
65.00	06500	RESPIRATORY THERAPY	0.291336	35,775	10,423	65.00
66.00	06600	PHYSICAL THERAPY	0.344519	122,525	42,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.360405	68,125	24,553	67.00
68.00	06800	SPEECH PATHOLOGY	0.806727	2,578	2,080	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.981482	20,107	19,735	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.588058	44,448	26,138	73.00
76.00	03050	CARDIAC REHAB	1.487311	3,818	5,679	76.00
76.01	03030	BEHAVIORAL HEALTH	0.813150	0	0	76.01
76.02	03040	WOUND CARE	0.646102	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.350335	0	0	90.00
91.00	09100	EMERGENCY	1.295206	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.636049	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		376,122	145,445	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)		376,122		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part B Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,303,560	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,303,560	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,346,596	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	31,273	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,500,960	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)	2,814,363	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)	2,814,363	30.00
31.00	Primary payer payments	1,535	31.00
32.00	Subtotal (line 30 minus line 31)	2,812,828	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)	232,752	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	176,892	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	225,352	36.00
37.00	Subtotal (see instructions)	2,989,720	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)	2,989,720	40.00
40.01	Sequestration adjustment (see instructions)	59,794	40.01
41.00	Interim payments	2,956,833	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-26,907	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: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,442,013		3,108,557	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	02/20/2015	210,888	02/20/2015	17,972	3.50
3.51		06/25/2015	91,181	06/25/2015	133,752	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)		-302,069		-151,724	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,139,944		2,956,833	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		14,556		26,907	6.02
7.00	Total Medicare program liability (see instructions)		1,125,388		2,929,926	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: 141306 | Component CCN: 14Z306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Swing Beds - SNF | Cost

		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		841,233		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	02/20/2015	38,956		0	3.01
3.02		06/25/2015	97,656		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)		136,612		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)		977,845		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		15,421		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		993,266		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: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part II Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Hospital | Cost

		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	183	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	456	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	544	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	25,673,630	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	77,660	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	164,104	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	164,104	8.00
9.00	Sequestration adjustment amount (see instructions)	3,282	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	160,822	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	160,822	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-2 | Date/Time Prepared: 11/20/2015 12:57 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	867,426	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	146,899	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	394	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,014,325	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,014,325	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,014,325	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	788	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,013,537	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,013,537	0	19.00
19.01	Sequestration adjustment (see instructions)	20,271	0	19.01
20.00	Interim payments	977,845	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	15,421	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141306	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/20/2015 12:57 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,245,188	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,245,188	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,257,640	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,257,640	19.00
20.00	Deductibles (exclude professional component)	125,867	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,131,773	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,131,773	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,819	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	16,582	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,603	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,148,355	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,148,355	30.00
30.01	Sequestration adjustment (see instructions)	22,967	30.01
31.00	Interim payments	1,139,944	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-14,556	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/20/2015 12:57 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	2,010,170	0	0	0	1.00
2.00	Temporary investments	835,300	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,270,566	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	298,347	0	0	0	7.00
8.00	Prepaid expenses	375,385	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)	5,789,768	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	532,386	0	0	0	12.00
13.00	Land improvements	527,547	0	0	0	13.00
14.00	Accumulated depreciation	-342,908	0	0	0	14.00
15.00	Buildings	3,502,795	0	0	0	15.00
16.00	Accumulated depreciation	-2,739,069	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,005,590	0	0	0	19.00
20.00	Accumulated depreciation	-1,690,361	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	4,657,296	0	0	0	23.00
24.00	Accumulated depreciation	-3,827,039	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	11,789,309	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,415,546	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	546,397	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	2,903,116	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,449,513	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,654,827	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,869,404	0	0	0	37.00
38.00	Salaries, wages, and fees payable	942,740	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	171,794	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	250,500	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,234,438	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	7,344,099	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,057	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	7,351,156	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	10,585,594	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,069,233				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)	13,069,233	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,654,827	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/20/2015 12:57 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		12,467,233		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		397,540				2.00
3.00	Total (sum of line 1 and line 2)		12,864,773		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		12,864,773		0		11.00
12.00	CHANGE IN INTEREST IN NET ASSETS	-204,460		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)		-204,460		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,069,233		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	CHANGE IN INTEREST IN NET ASSETS		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: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/20/2015 12:57 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	422,136		422,136	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	167,310		167,310	5.00
6.00	Swing bed - NF	19,534		19,534	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	608,980		608,980	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	608,980		608,980	17.00
18.00	Ancillary services	1,270,850	21,727,719	22,998,569	18.00
19.00	Outpatient services	5,190	2,083,488	2,088,678	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	106,565	2,015,250	2,121,815	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,991,585	25,826,457	27,818,042	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,185,527		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,185,527		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141306 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-3 | Date/Time Prepared: 11/20/2015 12:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	27,818,042	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,773,033	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,045,009	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,185,527	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-140,518	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	362,501	6.00
7.00	Income from investments	32,955	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	30,604	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	40,442	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	1,503	16.00
17.00	Revenue from sale of drugs to other than patients	6,095	17.00
18.00	Revenue from sale of medical records and abstracts	7,118	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	21,416	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	34,414	24.00
24.01	GAIN ON DISPOSAL OF ASSETS	1,010	24.01
25.00	Total other income (sum of lines 6-24)	538,058	25.00
26.00	Total (line 5 plus line 25)	397,540	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	397,540	29.00