

PART I - COST REPORT STATUS Date: 11/13/2014 Time: 8:47 am

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code:
 12. 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 GARFIELD PARK HOSPITAL (144039) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 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.

Encryption Information
 ECR: Date: 11/13/2014 Time: 8:47 am
 6sAFQVUecy118qa9b6u2wLqjlwdzv0
 GNTee04hpM0ntTORASRMEN5zH1tLvt
 :D3j0xRmYz09Zygg
 PI: Date: 11/13/2014 Time: 8:47 am
 I7dSEsA6fuWswBIU7sYYSBg1u9wkz0
 VA7lc0p34xp.0WJdxOvdwzclFehNjz
 HSjh0mj.Gj0Zzqzy

(Signed) *[Signature]*
 Officer or Administrator of Provider(s)
SVP CFO
 Title
 Date 11/18/14

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	0	0	0	-703,181	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	0	0	0	-703,181	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: 144039	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/12/2014 11:00 am
---	--	----------------------	---	---

	1.00	2.00	3.00	4.00	
Hospital and Hospital Health Care Complex Address:					
1.00	Street: 520 NORTH RIDGEWAY AVE		PO Box:		1.00
2.00	City: CHICAGO		State: IL	Zip Code: 60624	County: COOK

	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	GARFIELD PARK HOSPITAL	144039	16580	4	06/27/2013	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									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:	
20.00	Cost Reporting Period (mm/dd/yyyy)	1.00	2.00	20.00
21.00	Type of Control (see instructions)	07/01/2013	06/30/2014	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				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)									22.01
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.					2	N			23.00

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

		Urban/Rural S	Date of Geogr
		1.00	2.00
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144039	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/12/2014 11:00 am			
		Beginning: 1.00	Ending: 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 in effect in the cost reporting period.	0			37.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N 1.00	Y/N 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)				39.00		
		V 1.00	XVIII 2.00	XIX 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 worksheet L, Part III and L-1, Parts I through 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 Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.				58.00		
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part 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 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 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
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144039	Period: From 07/01/2013 To 06/30/2014	Worksheet s-2 Part I Date/Time Prepared: 11/12/2014 11:00 am		
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
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 Non-Provider Settings						
63.00	Has your facility trained residents in non-provider 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	
64.00	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. 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 non-provider 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
				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 non-provider 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144039		Period: From 07/01/2013 To 06/30/2014		Worksheet S-2 Part I Date/Time Prepared: 11/12/2014 11:00 am	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N		0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (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
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
					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/MR 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
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00		0.00
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
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144039	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/12/2014 11:00 am		
			V 1.00	XIX 2.00		
107.00	Column 1: 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 would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	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 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 hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	33,198		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
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	399001		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144039	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/12/2014 11:00 am
---	--	----------------------	---	---

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: UNIVERSAL HEALTH SERVICES, INC	Contractor's Name: HIGHMARK		Contractor's Number: 12001		141.00
142.00	Street: 367 S. GULPH RD	PO Box:				142.00
143.00	City: KING OF PRUSSIA	State: PA	Zip Code: 19406			143.00

						1.00	
144.00	Are provider based physicians' costs included in worksheet A?					Y	144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					N	145.00

		1.00	2.00	
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, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
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						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 Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0168.00
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)						0.00169.00

		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)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144039	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/12/2014 11:00 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N			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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been 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.	N			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	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

	Description	Part A		Part B	
		Y/N	Date	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.	Y		Y	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?	Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2012		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	UNIVERSAL HEALTH SERVICES, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-312-5742		KEVIN.SMITH@UHSINC.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		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.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-2
Part IX
Date/Time Prepared:
11/12/2014 11:00 am

		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	88	32,120	0.00		0
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
6.00 Hospital Adults & Peds. Swing Bed NF						0
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		88	32,120	0.00		0
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)		88	32,120	0.00		0
15.00 CAH visits						0
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		88				27.00
28.00 Observation Bed Days						0
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

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)	0	6,518	7,345			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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	6,518	7,345			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	6,518	7,345	0.00	85.03	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	85.03	27.00
28.00 Observation Bed Days		0	0			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

Component	Full Time	Discharges			Total All Patients	
	Equivalents	Title V	Title XVIII	Title XIX		
	Nonpaid Workers	12.00	13.00	14.00		
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)	11.00	0	0	484	562	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						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	0	484	562	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet A

Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		842,921	842,921	0	842,921	1.00
2.00	00200		211,663	211,663	27,565	239,228	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	77,122	974,617	1,051,739	0	1,051,739	4.00
5.00	00500	1,130,018	1,275,961	2,405,979	-233,577	2,172,402	5.00
7.00	00700	177,663	409,697	587,360	0	587,360	7.00
8.00	00800	0	46,277	46,277	0	46,277	8.00
9.00	00900	0	108,128	108,128	0	108,128	9.00
10.00	01000	105,681	133,921	239,602	-150	239,452	10.00
13.00	01300	238,653	24,704	263,357	0	263,357	13.00
16.00	01600	42,986	35,782	78,768	0	78,768	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,898,349	1,117,321	3,015,670	-66,923	2,948,747	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	139,649	2,114	141,763	66,923	208,686	90.00
SPECIAL PURPOSE COST CENTERS							
118.00		3,810,121	5,183,106	8,993,227	-206,162	8,787,065	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	206,162	206,162	194.00
194.01	07951	53,047	2,596	55,643	0	55,643	194.01
194.02	07953	0	0	0	0	0	194.02
200.00		3,863,168	5,185,702	9,048,870	0	9,048,870	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet A

Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	0	842,921	1.00	
2.00	00200	0	239,228	2.00	
3.00	00300	0	0	3.00	
4.00	00400	-8,257	1,043,482	4.00	
5.00	00500	-698,429	1,473,973	5.00	
7.00	00700	0	587,360	7.00	
8.00	00800	0	46,277	8.00	
9.00	00900	0	108,128	9.00	
10.00	01000	0	239,452	10.00	
13.00	01300	0	263,357	13.00	
16.00	01600	0	78,768	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	-686,610	2,262,137	30.00	
ANCILLARY SERVICE COST CENTERS					
60.00	06000	0	0	60.00	
69.00	06900	0	0	69.00	
70.00	07000	0	0	70.00	
73.00	07300	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	0	208,686	90.00	
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)		-1,393,296	7,393,769	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	0	0	192.00	
194.00	07950	0	206,162	194.00	
194.01	07951	0	55,643	194.01	
194.02	07953	0	0	194.02	
200.00	TOTAL (SUM OF LINES 118-199)		-1,393,296	7,655,574	200.00

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
ANCILLARY SERVICE COST CENTERS				
60.00	LABORATORY	06000		60.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	MARKETING	07950		194.00
194.01	EDUCATION	07951		194.01
194.02	PHP MEALS	07953		194.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - RENT LEASE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27,565	1.00	
2.00		0.00	0	0	2.00	
TOTALS			0	27,565		
B - MARKETING						
1.00	MARKETING	194.00	192,644	13,518	1.00	
TOTALS			192,644	13,518		
C - PSYCH TESTING						
1.00	CLINIC	90.00	45,882	21,041	1.00	
TOTALS			45,882	21,041		
500.00	Grand Total: Increases		238,526	62,124	500.00	

		Decreases				
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.	
6.00		7.00	8.00	9.00	10.00	
A - RENT LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,415	10	1.00
2.00	DIETARY	10.00	0	150	10	2.00
TOTALS			0	27,565		
B - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	192,644	13,518	0	1.00
TOTALS			192,644	13,518		
C - PSYCH TESTING						
1.00	ADULTS & PEDIATRICS	30.00	45,882	21,041	0	1.00
TOTALS			45,882	21,041		
500.00	Grand Total: Decreases		238,526	62,124		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
11/12/2014 11:00 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	16,639,266	0	16,639,266	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	0	1,277,637	0	1,277,637	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	17,916,903	0	17,916,903	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	17,916,903	0	17,916,903	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	16,639,266	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	1,277,637	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	17,916,903	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	17,916,903	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	422,972	0	0	17,278	402,671	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	208,972	0	0	2,691	0	2.00
3.00	Total (sum of lines 1-2)	631,944	0	0	19,969	402,671	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	842,921				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	211,663				2.00
3.00	Total (sum of lines 1-2)	0	1,054,584				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part III
Date/Time Prepared:
11/12/2014 11:00 am

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	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	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	0	422,972	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	208,972	27,565	2.00
3.00	Total (sum of lines 1-2)	0	0	0	631,944	27,565	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	17,278	402,671	0	842,921	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,691	0	0	239,228	2.00
3.00	Total (sum of lines 1-2)	0	19,969	402,671	0	1,082,149	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	A	-13,174	ADMINISTRATIVE & GENERAL	5.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-679,267				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	-362,987				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests		0		0.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts		0		0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines		0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0	32.00
33.00 MISC ADMIN	A	-2,887	ADMINISTRATIVE & GENERAL	5.00		0	33.00
33.01 BAD DEBT	A	-287,472	ADMINISTRATIVE & GENERAL	5.00		0	33.01

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8

Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
33.02	A	-10,196	ADMINISTRATIVE & GENERAL	5.00		0	33.02
33.03	A	13,174	ADMINISTRATIVE & GENERAL	5.00		0	33.03
33.04	A	-17,465	ADMINISTRATIVE & GENERAL	5.00		0	33.04
33.05	A	-7,343	ADULTS & PEDIATRICS	30.00		0	33.05
33.06	A	-1,714	ADMINISTRATIVE & GENERAL	5.00		0	33.06
33.07	A	-1,500	ADMINISTRATIVE & GENERAL	5.00		0	33.07
33.08	A	-22,465	ADMINISTRATIVE & GENERAL	5.00		0	33.08
33.09		0		0.00		0	33.09
33.10		0		0.00		0	33.10
33.11		0		0.00		0	33.11
33.12		0		0.00		0	33.12
33.13		0		0.00		0	33.13
33.14		0		0.00		0	33.14
33.15		0		0.00		0	33.15
50.00		-1,393,296					50.00
TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)							

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:
11/12/2014 11:00 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	0	281,893	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	288,804	300,600	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	8,257	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	61,041	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.		288,804	651,791	5.00

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

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

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

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

6.00	B	UHS, INC	100.00	UHS, INC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:
11/12/2014 11:00 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-281,893	0	1.00
2.00	-11,796	0	2.00
3.00	-8,257	0	3.00
4.00	-61,041	0	4.00
5.00	-362,987		5.00

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

Related Organization(s) and/or Home Office	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOSPITAL MGMT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-2

Date/Time Prepared:
11/12/2014 11:00 am

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	679,267	679,267	0	142,500	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			679,267	679,267	0		0	200.00

	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	679,267	1.00
2.00	0.00		0	0	0	0	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	679,267	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	842,921	842,921			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	239,228		239,228		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,043,482	0		1,043,482	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,473,973	85,513	24,269	258,352	1,842,107 5.00
7.00 00700	OPERATION OF PLANT	587,360	132,417	37,581	48,966	806,324 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	46,277	6,088	1,728	0	54,093 8.00
9.00 00900	HOUSEKEEPING	108,128	4,826	1,370	0	114,324 9.00
10.00 01000	DIETARY	239,452	63,922	18,142	29,127	350,643 10.00
13.00 01300	NURSING ADMINISTRATION	263,357	11,466	3,254	65,776	343,853 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	78,768	9,889	2,806	11,848	103,311 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,262,137	501,783	142,411	510,563	3,416,894 30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	0	0	0	0 60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	208,686	17,002	4,825	51,135	281,648 90.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,393,769	832,906	236,386	975,767	7,313,197 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	MARKETING	206,162	0	0	53,095	259,257 194.00
194.01 07951	EDUCATION	55,643	10,015	2,842	14,620	83,120 194.01
194.02 07953	PHP MEALS	0	0	0	0	0 194.02
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	7,655,574	842,921	239,228	1,043,482	7,655,574 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500	1,842,107					5.00	
7.00	00700	255,499	1,061,823				7.00	
8.00	00800	17,140	10,343	81,576			8.00	
9.00	00900	36,226	8,199	0	158,749		9.00	
10.00	01000	111,108	108,599	0	16,525	586,875	10.00	
13.00	01300	108,956	19,480	0	2,964	0	13.00	
16.00	01600	32,736	16,800	0	2,556	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	1,082,707	852,502	81,576	129,720	482,403	30.00	
ANCILLARY SERVICE COST CENTERS								
60.00	06000	0	0	0	0	0	60.00	
69.00	06900	0	0	0	0	0	69.00	
70.00	07000	0	0	0	0	0	70.00	
73.00	07300	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	89,246	28,885	0	4,395	0	90.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		1,733,618	1,044,808	81,576	156,160	482,403	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	82,151	0	0	0	0	194.00	
194.01	07951	26,338	17,015	0	2,589	0	194.01	
194.02	07953	0	0	0	0	104,472	194.02	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	TOTAL (sum lines 118-201)		1,842,107	1,061,823	81,576	158,749	586,875	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100					1.00	
2.00	00200					2.00	
4.00	00400					4.00	
5.00	00500					5.00	
7.00	00700					7.00	
8.00	00800					8.00	
9.00	00900					9.00	
10.00	01000					10.00	
13.00	01300	475,253				13.00	
16.00	01600	0	155,403			16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	475,253	139,463	6,660,518	0	6,660,518	
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	60.00	
69.00	06900	0	0	0	0	69.00	
70.00	07000	0	0	0	0	70.00	
73.00	07300	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	15,940	420,114	0	420,114	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)		475,253	155,403	7,080,632	0	7,080,632
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	192.00	
194.00	07950	0	0	341,408	0	341,408	
194.01	07951	0	0	129,062	0	129,062	
194.02	07953	0	0	104,472	0	104,472	
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)		475,253	155,403	7,655,574	0	7,655,574

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	P	TOTAL PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
13.00	NURSING ADMINISTRATION	P	TOTAL PATIENT DAYS	13.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,648	85,513	24,269	118,430	5.00
7.00 00700	OPERATION OF PLANT	0	132,417	37,581	169,998	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,088	1,728	7,816	8.00
9.00 00900	HOUSEKEEPING	0	4,826	1,370	6,196	9.00
10.00 01000	DIETARY	0	63,922	18,142	82,064	10.00
13.00 01300	NURSING ADMINISTRATION	0	11,466	3,254	14,720	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	9,889	2,806	12,695	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	501,783	142,411	644,194	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	17,002	4,825	21,827	90.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,648	832,906	236,386	1,077,940	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MARKETING	0	0	0	0	194.00
194.01 07951	EDUCATION	0	10,015	2,842	12,857	194.01
194.02 07953	PHP MEALS	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	8,648	842,921	239,228	1,090,797	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	118,430					5.00
7.00	00700	16,426	186,424				7.00
8.00	00800	1,102	1,816	10,734			8.00
9.00	00900	2,329	1,440	0	9,965		9.00
10.00	01000	7,143	19,067	0	1,037	109,311	10.00
13.00	01300	7,005	3,420	0	186	0	13.00
16.00	01600	2,105	2,950	0	160	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	69,607	149,673	10,734	8,143	89,852	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	5,738	5,071	0	276	0	90.00
SPECIAL PURPOSE COST CENTERS							
118.00		111,455	183,437	10,734	9,802	89,852	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	5,282	0	0	0	0	194.00
194.01	07951	1,693	2,987	0	163	0	194.01
194.02	07953	0	0	0	0	19,459	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		118,430	186,424	10,734	9,965	109,311	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		13.00	16.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
13.00	01300	25,331					13.00	
16.00	01600	0	17,910				16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	25,331	16,073	1,013,607	0	1,013,607	30.00	
ANCILLARY SERVICE COST CENTERS								
60.00	06000	0	0	0	0	0	60.00	
69.00	06900	0	0	0	0	0	69.00	
70.00	07000	0	0	0	0	0	70.00	
73.00	07300	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	1,837	34,749	0	34,749	90.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		25,331	17,910	1,048,356	0	1,048,356	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	0	0	5,282	0	5,282	194.00	
194.01	07951	0	0	17,700	0	17,700	194.01	
194.02	07953	0	0	19,459	0	19,459	194.02	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		25,331	17,910	1,090,797	0	1,090,797	202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQARE FEET)	MVBLE EQUIP (SQARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	53,446				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		53,446			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,786,046		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,422	5,422	937,374	-1,842,107	5.00
7.00 00700	OPERATION OF PLANT	8,396	8,396	177,663	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	386	386	0	0	8.00
9.00 00900	HOUSEKEEPING	306	306	0	0	9.00
10.00 01000	DIETARY	4,053	4,053	105,681	0	10.00
13.00 01300	NURSING ADMINISTRATION	727	727	238,653	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	627	627	42,986	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	31,816	31,816	1,852,467	0	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,078	1,078	185,531	0	90.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	52,811	52,811	3,540,355	-1,842,107	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MARKETING	0	0	192,644	0	194.00
194.01 07951	EDUCATION	635	635	53,047	0	194.01
194.02 07953	PHP MEALS	0	0	0	0	194.02
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)	842,921	239,228	1,043,482	1,842,107	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	15.771452	4.476069	0.275613	0.316869	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0	118,430	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000	0.020372	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		OPERATION OF PLANT (SQARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	39,628					7.00
8.00	00800	386	7,345				8.00
9.00	00900	306	0	38,936			9.00
10.00	01000	4,053	0	4,053	26,807		10.00
13.00	01300	727	0	727	0	7,345	13.00
16.00	01600	627	0	627	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	31,816	7,345	31,816	22,035	7,345	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,078	0	1,078	0	0	90.00
SPECIAL PURPOSE COST CENTERS							
118.00		38,993	7,345	38,301	22,035	7,345	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	635	0	635	0	0	194.01
194.02	07953	0	0	0	4,772	0	194.02
200.00							200.00
201.00							201.00
202.00		1,061,823	81,576	158,749	586,875	475,253	202.00
203.00		26.794766	11.106331	4.077178	21.892603	64.704289	203.00
204.00		186,424	10,734	9,965	109,311	25,331	204.00
205.00		4.704350	1.461402	0.255933	4.077704	3.448741	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		11,247,647	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		10,093,897	
ANCILLARY SERVICE COST CENTERS			
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		0	
		0	
		0	
		0	
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
		1,153,750	
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)		118.00
		11,247,647	
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MARKETING	194.00
194.01	07951	EDUCATION	194.01
194.02	07953	PHP MEALS	194.02
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)		202.00
		155,403	
203.00	Unit cost multiplier (wkst. B, Part I)		203.00
		0.013816	
204.00	Cost to be allocated (per wkst. B, Part II)		204.00
		17,910	
205.00	Unit cost multiplier (wkst. B, Part II)		205.00
		0.001592	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6,660,518		6,660,518	0	6,660,518
ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	0		0	0	0
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	420,114		420,114	0	420,114
200.00	Subtotal (see instructions)	7,080,632	0	7,080,632	0	7,080,632
201.00	Less observation Beds	0		0		0
202.00	Total (see instructions)	7,080,632	0	7,080,632	0	7,080,632

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description	Title XIX			Hospital	Cost			
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
6.00	7.00	8.00	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,093,897		10,093,897		30.00	
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,153,750	1,153,750	0.364129	0.000000	90.00
200.00		Subtotal (see instructions)	10,093,897	1,153,750	11,247,647			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,093,897	1,153,750	11,247,647			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet C
Part I
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.000000			60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

Cost Center Description		Title XIX	Hospital	Cost	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,345	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,345	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)			7,345	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			6,518	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			6,660,518	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,660,518	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			6,660,518	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)			906.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			5,910,588	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			5,910,588	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144039	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/12/2014 11:00 am		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,910,588 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet D-1

Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description	Cost	Title XIX		Hospital	Cost	
		Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,013,607	6,660,518	0.152181	0	0	90.00
91.00 Nursing School cost	0	6,660,518	0.000000	0	0	91.00
92.00 Allied health cost	0	6,660,518	0.000000	0	0	92.00
93.00 All other Medical Education	0	6,660,518	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144039	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/12/2014 11:00 am	
Cost Center Description		Title XIX	Hospital	Cost	
		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		8,970,242	30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0.000000	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.364129	0	90.00
200.00		Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144039	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/12/2014 11:00 am
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		5,910,588	1.00
2.00	Medical and other services			0 2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5,910,588	0 4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments			0 6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5,910,588	0 7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		8,970,242	8.00
9.00	Ancillary service charges		0	0 9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		8,970,242	0 12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0 13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0 14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000 15.00
16.00	Total customary charges (see instructions)		8,970,242	0 16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,059,654	0 17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0 18.00
19.00	Interns and Residents (see instructions)		0	0 19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0 20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		5,910,588	0 21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0 22.00
23.00	Outlier payments		0	0 23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0 26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0 27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0 28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		5,910,588	0 29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0 30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		5,910,588	0 31.00
32.00	Deductibles		0	0 32.00
33.00	Coinsurance		0	0 33.00
34.00	Allowable bad debts (see instructions)		0	0 34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		5,910,588	0 36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 37.00
38.00	Subtotal (line 36 ± line 37)		5,910,588	0 38.00
39.00	Direct graduate medical education payments (from wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		5,910,588	0 40.00
41.00	Interim payments		6,613,769	0 41.00
42.00	Balance due provider/program (line 40 minus line 41)		-703,181	0 42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0 43.00
OVERRIDES				
109.00	Override Ancillary service charges (line 9)		0	0 109.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet G

Date/Time Prepared:
11/12/2014 11:00 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	-46,196	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	2,833,610	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	51,353	0	0	0	7.00
8.00 Prepaid expenses	11,702	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)	2,850,469	0	0	0	11.00
FIXED ASSETS					
12.00 Land	50,000	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	16,604,475	0	0	0	15.00
16.00 Accumulated depreciation	-599,518	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	1,291,293	0	0	0	23.00
24.00 Accumulated depreciation	-294,971	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	17,051,279	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	2,046	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	2,046	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	19,903,794	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	407,032	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,335,768	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	23,015,281	0	0	0	43.00
44.00 Other current liabilities	-1	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	25,758,080	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	25,758,080	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	-5,854,283	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	-5,854,283	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	19,903,797	0	0	0	60.00

		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		-3,482,851		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-2,371,437			2.00
3.00	Total (sum of line 1 and line 2)		-5,854,288		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		-5,854,288		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-5,854,288		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/12/2014 11:00 am

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital	10,093,897		10,093,897	1.00
2.00 SUBPROVIDER - IPF				2.00
3.00 SUBPROVIDER - IRF				3.00
4.00 SUBPROVIDER				4.00
5.00 Swing bed - SNF	0		0	5.00
6.00 Swing bed - NF	0		0	6.00
7.00 SKILLED NURSING FACILITY				7.00
8.00 NURSING FACILITY				8.00
9.00 OTHER LONG TERM CARE				9.00
10.00 Total general inpatient care services (sum of lines 1-9)	10,093,897		10,093,897	10.00
Intensive Care Type Inpatient Hospital Services				
11.00 INTENSIVE CARE UNIT				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)	10,093,897		10,093,897	17.00
18.00 Ancillary services	0	0	0	18.00
19.00 Outpatient services	0	1,153,750	1,153,750	19.00
20.00 RURAL HEALTH CLINIC	0	0	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC				24.00
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE				26.00
27.00 PHYSICIAN REVENUE	517,921	105,372	623,293	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	10,611,818	1,259,122	11,870,940	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per wkst. A, column 3, line 200)		9,048,870		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)		9,048,870		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144039

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-3

Date/Time Prepared:
11/12/2014 11:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	11,870,940	1.00
2.00	Less contractual allowances and discounts on patients' accounts	5,196,394	2.00
3.00	Net patient revenues (line 1 minus line 2)	6,674,546	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	9,048,870	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,374,324	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	2,887	24.00
25.00	Total other income (sum of lines 6-24)	2,887	25.00
26.00	Total (line 5 plus line 25)	-2,371,437	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)	-2,371,437	29.00