This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141322	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/15/2016 11:20 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/15/2016 Time: 11:20 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABRAHAM LINCOLN MEMORIAL HOSPITAL (141322) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	357,933	-320,958	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-298,948	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	58,985	-320,958	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/10/2016 2:35 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 STAHLHUT DRIVE	PO Box:			1.00
2.00	City: LINCOLN	State: IL	Zip Code: 62656	County: LOGAN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ABRAHAM LINCOLN MEMORIAL HOSPITAL	141322	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ABRAHAM LINCOLN MEMORIAL HOSPITAL	14Z322	99914		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/10/2016 2:35 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/10/2016 2:35 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/10/2016 2:35 pm

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

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

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

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

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

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	71,755	0	0	118.01

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

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				1.00	2.00	
	All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y	14H058	140.00
	1.00	2.00	3.00			
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: MEMORIAL HELATH SYSTEM	Contractor's Name: NGS	Contractor's Number: 00131			141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:				142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781			143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141322	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/10/2016 2:35 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/10/2016 2:35 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	12/09/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/10/2016 2:35 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/10/2016 2:35 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	12/09/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/10/2016 2:35 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	91,458.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	91,458.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	91,458.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/10/2016 2:35 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,523	150	3,389			1.00
2.00	HMO and other (see instructions)	581	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	657	0	661			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	152			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,180	150	4,202			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		108	463			13.00
14.00	Total (see instructions)	2,180	258	4,665	0.00	227.73	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	227.73	27.00
28.00	Observation Bed Days		11	286			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			50			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	64			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/10/2016 2:35 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	421	56	1,003	1.00
2.00	HMO and other (see instructions)			134	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	421	56	1,003	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/10/2016 2:35 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.342044	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,280,338	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,336,050	5.00
6.00	Medicaid charges	15,577,345	6.00
7.00	Medicaid cost (line 1 times line 6)	5,328,137	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	711,749	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	16,708	9.00
10.00	Stand-alone SCHIP charges	111,420	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	38,111	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	21,403	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	733,152	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,865,475	850,613	2,716,088	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	638,075	290,947	929,022	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	638,075	290,947	929,022	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,041,535	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	366,135	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,675,400	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	573,061	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,502,083	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,235,235	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,109,422	3,109,422	2,345,732	5,455,154	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,572,048	1,572,048	80,848	1,652,896	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	100,921	4,552,646	4,653,567	0	4,653,567	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,691,760	4,972,731	6,664,491	-26,758	6,637,733	5.00
7.00	00700	OPERATION OF PLANT	425,121	637,918	1,063,039	0	1,063,039	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	179,340	179,340	8.00
9.00	00900	HOUSEKEEPING	390,066	228,693	618,759	-179,340	439,419	9.00
10.00	01000	DIETARY	510,305	378,171	888,476	-551,455	337,021	10.00
11.00	01100	CAFETERIA	0	0	0	547,671	547,671	11.00
13.00	01300	NURSING ADMINISTRATION	346,952	12,885	359,837	-4,270	355,567	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	250,265	259,483	509,748	-201,210	308,538	14.00
15.00	01500	PHARMACY	453,458	1,427,501	1,880,959	-1,402,445	478,514	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	411,406	89,972	501,378	0	501,378	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	38,178	38,178	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,428,188	394,286	1,822,474	688,754	2,511,228	30.00
43.00	04300	NURSERY	0	0	0	105,109	105,109	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	838,887	921,132	1,760,019	-255,225	1,504,794	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	750,570	162,378	912,948	-793,863	119,085	52.00
53.00	05300	ANESTHESIOLOGY	853,778	299,331	1,153,109	0	1,153,109	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,256,250	648,372	1,904,622	-33,891	1,870,731	54.00
60.00	06000	LABORATORY	849,201	1,025,557	1,874,758	0	1,874,758	60.00
65.00	06500	RESPIRATORY THERAPY	411,544	22,789	434,333	-2,706	431,627	65.00
66.00	06600	PHYSICAL THERAPY	1,390,277	57,139	1,447,416	0	1,447,416	66.00
68.00	06800	SPEECH PATHOLOGY	82,292	0	82,292	0	82,292	68.00
69.00	06900	ELECTROCARDIOLOGY	107,818	64,956	172,774	0	172,774	69.00
69.01	06902	CARDIAC REHABILITATION	120,873	10,650	131,523	0	131,523	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	127,612	127,612	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	329,185	329,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,446,734	1,446,734	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,265,823	2,696,495	3,962,318	-38,178	3,924,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,399,822	2,399,822	-2,399,822	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,935,755	25,944,377	39,880,132	0	39,880,132	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	13,935,755	25,944,377	39,880,132	0	39,880,132	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-238,413	5,216,741		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-288,634	1,364,262		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-84,648	4,568,919		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-889,997	5,747,736		5.00
7.00	00700	OPERATION OF PLANT	0	1,063,039		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	179,340		8.00
9.00	00900	HOUSEKEEPING	0	439,419		9.00
10.00	01000	DIETARY	0	337,021		10.00
11.00	01100	CAFETERIA	-142,699	404,972		11.00
13.00	01300	NURSING ADMINISTRATION	0	355,567		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	308,538		14.00
15.00	01500	PHARMACY	0	478,514		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,321	500,057		16.00
17.00	01700	SOCIAL SERVICE	0	38,178		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,511,228		30.00
43.00	04300	NURSERY	0	105,109		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-700	1,504,094		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	119,085		52.00
53.00	05300	ANESTHESIOLOGY	-853,778	299,331		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,870,731		54.00
60.00	06000	LABORATORY	-24,562	1,850,196		60.00
65.00	06500	RESPIRATORY THERAPY	0	431,627		65.00
66.00	06600	PHYSICAL THERAPY	-38,455	1,408,961		66.00
68.00	06800	SPEECH PATHOLOGY	0	82,292		68.00
69.00	06900	ELECTROCARDIOLOGY	0	172,774		69.00
69.01	06902	CARDIAC REHABILITATION	0	131,523		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	127,612		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	329,185		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,446,734		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,181,557	1,742,583		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,744,764	35,135,368		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,744,764	35,135,368		200.00

RECLASSIFICATIONS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/10/2016 2:35 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS STERILE PROCESSING SALARIES					
1.00	OPERATING ROOM	50.00	60,332	36,956		1.00
	0		60,332	36,956		
	B - RECLASS LABOR & DELIVERY EXPENSES					
1.00	NURSERY	43.00	86,414	18,695		1.00
2.00	ADULTS & PEDIATRICS	30.00	566,251	122,503		2.00
	0		652,665	141,198		
	C - RECLASS SOCIAL SERVICE FEES					
1.00	SOCIAL SERVICE	17.00	0	38,178		1.00
	0		0	38,178		
	D - RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	26,758		1.00
	0		0	26,758		
	E - RECLASS DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,446,734		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	1,446,734		
	F - RECLASS LAUNDRY EXPENSE					
1.00	LAUNDRY & LINEN SERVICE	8.00	35,551	143,789		1.00
	0		35,551	143,789		
	G - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	127,612		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	329,185		2.00
3.00		0.00	0	0		3.00
	0		0	456,797		
	H - RECLASS CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	315,906	231,765		1.00
	0		315,906	231,765		
	I - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,195,740		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	70,012		2.00
	0		0	2,265,752		
	J - RECLASS BOND AMORTIZATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129,927		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,143		2.00
	0		0	134,070		
500.00	Grand Total: Increases		1,064,454	4,921,997		500.00

RECLASSIFICATIONS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/10/2016 2:35 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RECLASS STERILE PROCESSING SALARIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	60,332	36,956	0	1.00
	0		60,332	36,956		
	B - RECLASS LABOR & DELIVERY EXPENSES					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	652,665	141,198	0	1.00
2.00		0.00	0	0	0	2.00
	0		652,665	141,198		
	C - RECLASS SOCIAL SERVICE FEES					
1.00	EMERGENCY	91.00	0	38,178	0	1.00
	0		0	38,178		
	D - RECLASS PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,758	0	1.00
	0		0	26,758		
	E - RECLASS DRUG EXPENSE					
1.00	DIETARY	10.00	0	3,784	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	4,270	0	2.00
3.00	PHARMACY	15.00	0	1,402,083	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	33,891	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0	2,706	0	5.00
	0		0	1,446,734		
	F - RECLASS LAUNDRY EXPENSE					
1.00	HOUSEKEEPING	9.00	35,551	143,789	0	1.00
	0		35,551	143,789		
	G - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	103,922	0	1.00
2.00	PHARMACY	15.00	0	362	0	2.00
3.00	OPERATING ROOM	50.00	0	352,513	0	3.00
	0		0	456,797		
	H - RECLASS CAFETERIA EXPENSE					
1.00	DIETARY	10.00	315,906	231,765	0	1.00
	0		315,906	231,765		
	I - RECLASS INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	2,265,752	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	2,265,752		
	J - RECLASS BOND AMORTIZATION EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	134,070	14	1.00
2.00		0.00	0	0	14	2.00
	0		0	134,070		
500.00	Grand Total: Decreases		1,064,454	4,921,997		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/10/2016 2:35 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	834,848	0	0	0	0	1.00
2.00	Land Improvements	5,976,845	0	0	0	0	2.00
3.00	Buildings and Fixtures	42,089,310	27,511	0	27,511	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,221,846	611,522	0	611,522	37,356	6.00
7.00	HIT designated Assets	2,526,077	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,648,926	639,033	0	639,033	37,356	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	64,648,926	639,033	0	639,033	37,356	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	834,848	0	1.00
2.00	Land Improvements	5,976,845	0	2.00
3.00	Buildings and Fixtures	42,116,821	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	13,796,012	0	6.00
7.00	HIT designated Assets	2,526,077	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,250,603	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	65,250,603	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/10/2016 2:35 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,109,422	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,572,048	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,681,470	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,109,422	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,572,048	2.00
3.00	Total (sum of lines 1-2)	0	4,681,470	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/10/2016 2:35 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	48,928,514	0	48,928,514	0.749855	20,065	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,322,089	0	16,322,089	0.250145	6,693	2.00
3.00	Total (sum of lines 1-2)	65,250,603	0	65,250,603	1.000000	26,758	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	20,065	3,116,882	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	6,693	1,291,254	0	2.00
3.00	Total (sum of lines 1-2)	0	0	26,758	4,408,136	0	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	1,949,867	20,065	0	129,927	5,216,741	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	62,172	6,693	0	4,143	1,364,262	2.00
3.00	Total (sum of lines 1-2)	2,012,039	26,758	0	134,070	6,581,003	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/10/2016 2:35 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-245,873	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-7,840	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-1,886	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,202,499			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	214,992			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-142,699	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,321	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-282,237	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00			0		0.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/10/2016 2:35 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	LABORATORY MISCELLANEOUS REVENUE	B	-3,620	LABORATORY	60.00	0	33.01
33.02			0		0.00	0	33.02
33.03	OR MISCELLANEOUS REVENUE	B	-700	OPERATING ROOM	50.00	0	33.03
33.04	PHYSICAL THERAPY MISCELLANEOUS REVE	B	-38,455	PHYSICAL THERAPY	66.00	0	33.04
33.05			0		0.00	0	33.05
33.06	MISCELLANEOUS REVENUE	B	-77,528	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MANAGEMENT FEE REVENUE	B	-15,600	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	CRNA SALARIES	A	-853,778	ANESTHESIOLOGY	53.00	0	33.08
33.09	CRNA BENEFITS EXPENSE	A	-74,905	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	MARKETING SALARY	A	-39,584	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MARKETING BENEFITS EXPENSE	A	-9,743	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	MARKETING OTHER EXPENSE	A	-26,381	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ADVERTISING EXPENSE	A	-72,835	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	LOBBYING EXPENSE	A	-19,412	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	PROVIDER TAX	A	-862,219	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16			0		0.00	0	33.16
33.17	FUNDED DEPRECIATION TRUSTEE FEES	A	30,093	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	MISCELLANEOUS REVENUE	B	-10,734	ADMINISTRATIVE & GENERAL	5.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,744,764				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141322	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/10/2016 2:35 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HO BUILDING CAPITAL	7,460	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO MME CAPITAL	1,443	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST OPERATING	16,845	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HO MANAGEMENT OPERATING	2,645,776	2,303,284	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	SELF INSURANCE BENEFITS	1,850,595	2,003,843	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	PRINT SHOP & SUPPLIES - MMC	73,183	73,183	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,595,302	4,380,310	5.00

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

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

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

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

6.00	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	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: 141322	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/10/2016 2:35 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	7,460	9		1.00
2.00	1,443	9		2.00
3.00	16,845	0		3.00
4.00	342,492	0		4.00
4.01	-153,248	0		4.01
4.02	0	0		4.02
5.00	214,992			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	MANAGEMENT/HO		6.00
7.00	HOSPITAL		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: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/10/2016 2:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4,891	0	4,891	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	212	0	212	0	0	2.00
3.00	50.00	OPERATING ROOM	26,246	0	26,246	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	239,011	0	239,011	0	0	4.00
5.00	60.00	LABORATORY	20,942	20,942	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	720	0	720	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	2,520	0	2,520	0	0	7.00
8.00	69.01	CARDIAC REHABILITATION	4,290	0	4,290	0	0	8.00
9.00	91.00	EMERGENCY	2,361,564	2,181,557	180,007	0	0	9.00
10.00	91.00	EMERGENCY	78,871	0	78,871	0	0	10.00
200.00			2,739,267	2,202,499	536,768		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	69.01	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	0		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0		4.00
5.00	60.00	LABORATORY	0	0	0	20,942		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0		7.00
8.00	69.01	CARDIAC REHABILITATION	0	0	0	0		8.00
9.00	91.00	EMERGENCY	0	0	0	2,181,557		9.00
10.00	91.00	EMERGENCY	0	0	0	0		10.00
200.00			0	0	0	2,202,499		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/10/2016 2:35 pm

		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	5,216,741	5,216,741				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,364,262		1,364,262			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,568,919	5,154	0	4,574,073		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,747,736	368,301	120,887	583,950	6,820,874	5.00
7.00	00700	OPERATION OF PLANT	1,063,039	1,633,828	60,178	150,256	2,907,301	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	179,340	25,244	0	12,565	217,149	8.00
9.00	00900	HOUSEKEEPING	439,419	141,197	0	125,301	705,917	9.00
10.00	01000	DIETARY	337,021	188,908	24,353	68,709	618,991	10.00
11.00	01100	CAFETERIA	404,972	0	39,582	111,655	556,209	11.00
13.00	01300	NURSING ADMINISTRATION	355,567	9,119	0	122,628	487,314	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	308,538	104,102	1,038	67,130	480,808	14.00
15.00	01500	PHARMACY	478,514	57,228	5,556	160,272	701,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	500,057	79,960	0	145,409	725,426	16.00
17.00	01700	SOCIAL SERVICE	38,178	0	0	0	38,178	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,511,228	811,099	89,103	704,919	4,116,349	30.00
43.00	04300	NURSERY	105,109	16,388	6,308	30,542	158,347	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,504,094	456,631	233,130	317,823	2,511,678	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	119,085	23,525	5,573	34,604	182,787	52.00
53.00	05300	ANESTHESIOLOGY	299,331	13,393	28,333	0	341,057	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,870,731	330,678	604,221	444,013	3,249,643	54.00
60.00	06000	LABORATORY	1,850,196	198,644	53,288	300,144	2,402,272	60.00
65.00	06500	RESPIRATORY THERAPY	431,627	39,826	14,702	145,457	631,612	65.00
66.00	06600	PHYSICAL THERAPY	1,408,961	223,447	24,453	491,384	2,148,245	66.00
68.00	06800	SPEECH PATHOLOGY	82,292	4,758	0	29,086	116,136	68.00
69.00	06900	ELECTROCARDIOLOGY	172,774	7,886	13,751	38,108	232,519	69.00
69.01	06902	CARDIAC REHABILITATION	131,523	172,476	0	42,722	346,721	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	127,612	0	0	0	127,612	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,185	0	0	0	329,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,446,734	0	0	0	1,446,734	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,742,583	264,198	39,806	447,396	2,493,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,135,368	5,175,990	1,364,262	4,574,073	35,094,617	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,751	0	0	40,751	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	35,135,368	5,216,741	1,364,262	4,574,073	35,135,368	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,820,874					5.00
7.00	00700	OPERATION OF PLANT	700,360	3,607,661				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,311	28,376	297,836			8.00
9.00	00900	HOUSEKEEPING	170,053	158,715	0	1,034,685		9.00
10.00	01000	DIETARY	149,113	212,346	533	64,232	1,045,215	10.00
11.00	01100	CAFETERIA	133,989	0	867	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	117,392	10,251	0	3,101	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	115,825	117,018	455	35,397	0	14.00
15.00	01500	PHARMACY	169,006	64,328	0	19,458	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	174,753	89,881	0	27,188	0	16.00
17.00	01700	SOCIAL SERVICE	9,197	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	991,614	911,734	78,572	275,790	1,018,879	30.00
43.00	04300	NURSERY	38,145	18,422	2,540	5,572	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	605,056	513,286	36,558	155,263	5,085	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,033	26,444	2,878	7,999	0	52.00
53.00	05300	ANESTHESIOLOGY	82,160	15,054	0	4,554	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	782,829	371,705	41,229	112,437	0	54.00
60.00	06000	LABORATORY	578,700	223,291	9	67,543	0	60.00
65.00	06500	RESPIRATORY THERAPY	152,153	44,767	0	13,542	0	65.00
66.00	06600	PHYSICAL THERAPY	517,506	251,171	38,732	75,976	0	66.00
68.00	06800	SPEECH PATHOLOGY	27,977	5,348	0	1,618	0	68.00
69.00	06900	ELECTROCARDIOLOGY	56,013	8,864	5,983	2,681	0	69.00
69.01	06902	CARDIAC REHABILITATION	83,524	193,875	0	58,645	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,741	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	79,300	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	348,514	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	600,793	296,978	80,125	89,833	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,811,057	3,561,854	288,481	1,020,829	1,023,964	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,817	45,807	0	13,856	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	9,355	0	21,251	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,820,874	3,607,661	297,836	1,034,685	1,045,215	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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
11.00	01100	CAFETERIA	691,065					11.00
13.00	01300	NURSING ADMINISTRATION	17,465	635,523				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,633	1,007	771,143			14.00
15.00	01500	PHARMACY	19,568	0	1,237	975,167		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,658	0	33	0	1,061,939	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	151,383	281,841	58,510	0	214,752	30.00
43.00	04300	NURSERY	4,850	11,435	790	0	16,719	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,273	134,909	123,746	0	107,808	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,467	12,956	895	0	7,495	52.00
53.00	05300	ANESTHESIOLOGY	13,905	0	9,367	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,664	0	44,411	0	45,545	54.00
60.00	06000	LABORATORY	73,757	0	277,654	0	56,787	60.00
65.00	06500	RESPIRATORY THERAPY	27,501	0	3,302	0	14,701	65.00
66.00	06600	PHYSICAL THERAPY	82,280	0	5,005	0	5,765	66.00
68.00	06800	SPEECH PATHOLOGY	3,869	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,560	0	1,196	0	15,854	69.00
69.01	06902	CARDIAC REHABILITATION	7,149	0	906	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	53,034	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	136,804	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	975,167	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	82,083	193,375	54,253	0	530,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	691,065	635,523	771,143	975,167	1,015,818	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	46,121	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	691,065	635,523	771,143	975,167	1,061,939	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	47,375					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,099,424	0	8,099,424		30.00
43.00	04300	NURSERY	0	256,820	0	256,820		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,250,662	0	4,250,662		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	290,954	0	290,954		52.00
53.00	05300	ANESTHESIOLOGY	0	466,097	0	466,097		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,720,463	0	4,720,463		54.00
60.00	06000	LABORATORY	0	3,680,013	0	3,680,013		60.00
65.00	06500	RESPIRATORY THERAPY	0	887,578	0	887,578		65.00
66.00	06600	PHYSICAL THERAPY	0	3,124,680	0	3,124,680		66.00
68.00	06800	SPEECH PATHOLOGY	0	154,948	0	154,948		68.00
69.00	06900	ELECTROCARDIOLOGY	0	329,670	0	329,670		69.00
69.01	06902	CARDIAC REHABILITATION	0	690,820	0	690,820		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	211,387	0	211,387		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	545,289	0	545,289		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,770,415	0	2,770,415		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	47,375	4,469,190	0	4,469,190		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,375	34,948,410	0	34,948,410		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	156,352	0	156,352		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,606	0	30,606		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	47,375	35,135,368	0	35,135,368		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,154	0	5,154	5,154	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,964	368,301	120,887	499,152	658	5.00
7.00	00700	OPERATION OF PLANT	10,318	1,633,828	60,178	1,704,324	169	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,244	0	25,244	14	8.00
9.00	00900	HOUSEKEEPING	0	141,197	0	141,197	141	9.00
10.00	01000	DIETARY	0	188,908	24,353	213,261	77	10.00
11.00	01100	CAFETERIA	0	0	39,582	39,582	126	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,119	0	9,119	138	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	104,102	1,038	105,140	76	14.00
15.00	01500	PHARMACY	0	57,228	5,556	62,784	180	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	79,960	0	79,960	164	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,728	811,099	89,103	905,930	797	30.00
43.00	04300	NURSERY	0	16,388	6,308	22,696	34	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	58,909	456,631	233,130	748,670	358	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	23,525	5,573	29,098	39	52.00
53.00	05300	ANESTHESIOLOGY	0	13,393	28,333	41,726	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	132	330,678	604,221	935,031	500	54.00
60.00	06000	LABORATORY	125	198,644	53,288	252,057	338	60.00
65.00	06500	RESPIRATORY THERAPY	884	39,826	14,702	55,412	164	65.00
66.00	06600	PHYSICAL THERAPY	145	223,447	24,453	248,045	553	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,758	0	4,758	33	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,886	13,751	21,637	43	69.00
69.01	06902	CARDIAC REHABILITATION	0	172,476	0	172,476	48	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	264,198	39,806	304,004	504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,205	5,175,990	1,364,262	6,626,457	5,154	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,751	0	40,751	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	86,205	5,216,741	1,364,262	6,667,208	5,154	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	499,810					5.00
7.00	00700	OPERATION OF PLANT	51,320	1,755,813				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,833	13,810	42,901			8.00
9.00	00900	HOUSEKEEPING	12,461	77,245	0	231,044		9.00
10.00	01000	DIETARY	10,926	103,347	77	14,343	342,031	10.00
11.00	01100	CAFETERIA	9,818	0	125	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,602	4,989	0	692	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,487	56,952	65	7,904	0	14.00
15.00	01500	PHARMACY	12,384	31,308	0	4,345	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,805	43,744	0	6,071	0	16.00
17.00	01700	SOCIAL SERVICE	674	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,665	443,732	11,318	61,585	333,413	30.00
43.00	04300	NURSERY	2,795	8,966	366	1,244	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,336	249,811	5,266	34,670	1,664	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,227	12,870	415	1,786	0	52.00
53.00	05300	ANESTHESIOLOGY	6,020	7,327	0	1,017	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,363	180,905	5,939	25,107	0	54.00
60.00	06000	LABORATORY	42,405	108,673	1	15,082	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,149	21,788	0	3,024	0	65.00
66.00	06600	PHYSICAL THERAPY	37,921	122,242	5,579	16,965	0	66.00
68.00	06800	SPEECH PATHOLOGY	2,050	2,603	0	361	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,104	4,314	862	599	0	69.00
69.01	06902	CARDIAC REHABILITATION	6,120	94,357	0	13,095	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,253	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,811	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,538	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	44,024	144,536	11,540	20,060	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	499,091	1,733,519	41,553	227,950	335,077	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	719	22,294	0	3,094	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,348	0	6,954	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	499,810	1,755,813	42,901	231,044	342,031	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	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
11.00	01100	CAFETERIA	49,651					11.00
13.00	01300	NURSING ADMINISTRATION	1,255	24,795				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,482	39	180,145			14.00
15.00	01500	PHARMACY	1,406	0	289	112,696		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,209	0	8	0	145,961	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,876	10,997	13,669	0	29,517	30.00
43.00	04300	NURSERY	348	446	185	0	2,298	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,115	5,263	28,908	0	14,818	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	393	505	209	0	1,030	52.00
53.00	05300	ANESTHESIOLOGY	999	0	2,188	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,221	0	10,375	0	6,260	54.00
60.00	06000	LABORATORY	5,299	0	64,860	0	7,805	60.00
65.00	06500	RESPIRATORY THERAPY	1,976	0	771	0	2,021	65.00
66.00	06600	PHYSICAL THERAPY	5,912	0	1,169	0	792	66.00
68.00	06800	SPEECH PATHOLOGY	278	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	471	0	280	0	2,179	69.00
69.01	06902	CARDIAC REHABILITATION	514	0	212	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	12,389	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	31,959	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	112,696	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,897	7,545	12,674	0	72,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,651	24,795	180,145	112,696	139,622	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	6,339	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	49,651	24,795	180,145	112,696	145,961	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	674					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,894,499	0	1,894,499		30.00
43.00	04300	NURSERY	0	39,378	0	39,378		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,137,879	0	1,137,879		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,572	0	49,572		52.00
53.00	05300	ANESTHESIOLOGY	0	59,277	0	59,277		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,226,701	0	1,226,701		54.00
60.00	06000	LABORATORY	0	496,520	0	496,520		60.00
65.00	06500	RESPIRATORY THERAPY	0	96,305	0	96,305		65.00
66.00	06600	PHYSICAL THERAPY	0	439,178	0	439,178		66.00
68.00	06800	SPEECH PATHOLOGY	0	10,083	0	10,083		68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,489	0	34,489		69.00
69.01	06902	CARDIAC REHABILITATION	0	286,822	0	286,822		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,642	0	14,642		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	37,770	0	37,770		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	138,234	0	138,234		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	674	624,360	0	624,360		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	674	6,585,709	0	6,585,709		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	73,197	0	73,197		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,302	0	8,302		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	674	6,667,208	0	6,667,208		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	118,414					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,289,811				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117	0	12,941,472			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,360	114,290	1,652,176	-6,820,874	28,314,494	5.00
7.00	00700	OPERATION OF PLANT	37,086	56,894	425,121	0	2,907,301	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	0	35,551	0	217,149	8.00
9.00	00900	HOUSEKEEPING	3,205	0	354,515	0	705,917	9.00
10.00	01000	DIETARY	4,288	23,024	194,399	0	618,991	10.00
11.00	01100	CAFETERIA	0	37,422	315,906	0	556,209	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	346,952	0	487,314	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	981	189,933	0	480,808	14.00
15.00	01500	PHARMACY	1,299	5,253	453,458	0	701,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	411,406	0	725,426	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	38,178	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,411	84,240	1,994,439	0	4,116,349	30.00
43.00	04300	NURSERY	372	5,964	86,414	0	158,347	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	220,408	899,219	0	2,511,678	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	534	5,269	97,905	0	182,787	52.00
53.00	05300	ANESTHESIOLOGY	304	26,787	0	0	341,057	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	571,245	1,256,250	0	3,249,643	54.00
60.00	06000	LABORATORY	4,509	50,380	849,201	0	2,402,272	60.00
65.00	06500	RESPIRATORY THERAPY	904	13,900	411,544	0	631,612	65.00
66.00	06600	PHYSICAL THERAPY	5,072	23,119	1,390,277	0	2,148,245	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	82,292	0	116,136	68.00
69.00	06900	ELECTROCARDIOLOGY	179	13,001	107,818	0	232,519	69.00
69.01	06902	CARDIAC REHABILITATION	3,915	0	120,873	0	346,721	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	127,612	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	329,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,446,734	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	37,634	1,265,823	0	2,493,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,489	1,289,811	12,941,472	-6,820,874	28,273,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	0	0	40,751	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,216,741	1,364,262	4,574,073		6,820,874	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.055103	1.057722	0.353443		0.240897	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,154		499,810	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000398		0.017652	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	72,851					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	573	224,674				8.00
9.00	00900	HOUSEKEEPING	3,205	0	69,073			9.00
10.00	01000	DIETARY	4,288	402	4,288	21,789		10.00
11.00	01100	CAFETERIA	0	654	0	0	24,651	11.00
13.00	01300	NURSING ADMINISTRATION	207	0	207	0	623	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,363	343	2,363	0	736	14.00
15.00	01500	PHARMACY	1,299	0	1,299	0	698	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,815	0	1,815	0	1,593	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,411	59,271	18,411	21,240	5,400	30.00
43.00	04300	NURSERY	372	1,916	372	0	173	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,365	27,578	10,365	106	2,043	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	534	2,171	534	0	195	52.00
53.00	05300	ANESTHESIOLOGY	304	0	304	0	496	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,506	31,101	7,506	0	2,592	54.00
60.00	06000	LABORATORY	4,509	7	4,509	0	2,631	60.00
65.00	06500	RESPIRATORY THERAPY	904	0	904	0	981	65.00
66.00	06600	PHYSICAL THERAPY	5,072	29,218	5,072	0	2,935	66.00
68.00	06800	SPEECH PATHOLOGY	108	0	108	0	138	68.00
69.00	06900	ELECTROCARDIOLOGY	179	4,513	179	0	234	69.00
69.01	06902	CARDIAC REHABILITATION	3,915	0	3,915	0	255	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,997	60,443	5,997	0	2,928	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,926	217,617	68,148	21,346	24,651	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	925	0	925	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,057	0	443	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,607,661	297,836	1,034,685	1,045,215	691,065	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.521091	1.325636	14.979587	47.969847	28.033954	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,755,813	42,901	231,044	342,031	49,651	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	24.101426	0.190948	3.344925	15.697416	2.014158	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/10/2016 2:35 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	128,712					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	204	1,855,564				14.00
15.00	01500	PHARMACY	0	2,977	1,446,734			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	79	0	3,684		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	360	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,081	140,791	0	745	0	30.00
43.00	04300	NURSERY	2,316	1,902	0	58	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,323	297,763	0	374	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,624	2,154	0	26	0	52.00
53.00	05300	ANESTHESIOLOGY	0	22,540	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	106,863	0	158	0	54.00
60.00	06000	LABORATORY	0	668,104	0	197	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,946	0	51	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,044	0	20	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,879	0	55	0	69.00
69.01	06902	CARDIAC REHABILITATION	0	2,179	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	127,612	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	329,185	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,446,734	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	39,164	130,546	0	1,840	360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,712	1,855,564	1,446,734	3,524	360	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	160	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	635,523	771,143	975,167	1,061,939	47,375	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.937558	0.415584	0.674047	288.257058	131.597222	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,795	180,145	112,696	145,961	674	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.192639	0.097084	0.077897	39.620250	1.872222	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,099,424		8,099,424	0	0	30.00
43.00	04300	NURSERY	256,820		256,820	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,250,662		4,250,662	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	290,954		290,954	0	0	52.00
53.00	05300	ANESTHESIOLOGY	466,097		466,097	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,720,463		4,720,463	0	0	54.00
60.00	06000	LABORATORY	3,680,013		3,680,013	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	887,578	0	887,578	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,124,680	0	3,124,680	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	154,948	0	154,948	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	329,670		329,670	0	0	69.00
69.01	06902	CARDIAC REHABILITATION	690,820		690,820	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	211,387		211,387	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	545,289		545,289	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,770,415		2,770,415	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,469,190		4,469,190	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	532,812		532,812		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	35,481,222	0	35,481,222	0	0	200.00
201.00		Less Observation Beds	532,812		532,812		0	201.00
202.00		Total (see instructions)	34,948,410	0	34,948,410	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,202,682		5,202,682			30.00
43.00	04300	NURSERY	363,690		363,690			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,141,515	6,016,722	7,158,237	0.593814	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,016,256	1,224,531	2,240,787	0.129845	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	277,526	945,405	1,222,931	0.381131	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,016,135	32,375,512	33,391,647	0.141367	0.000000	54.00
60.00	06000	LABORATORY	2,022,799	12,775,226	14,798,025	0.248683	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	607,772	1,632,451	2,240,223	0.396201	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	452,592	4,719,700	5,172,292	0.604119	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	53,880	227,153	281,033	0.551352	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	334,562	1,448,306	1,782,868	0.184910	0.000000	69.00
69.01	06902	CARDIAC REHABILITATION	0	790,278	790,278	0.874148	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,028,813	1,025,332	2,054,145	0.102908	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,178,693	645,550	1,824,243	0.298912	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,778,896	7,126,875	9,905,771	0.279677	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	391,480	12,628,896	13,020,376	0.343246	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,541	717,494	726,035	0.733865	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,875,832	84,299,431	102,175,263			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,875,832	84,299,431	102,175,263			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06902	CARDIAC REHABILITATION	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,137,879	7,158,237	0.158961	258,986	41,169	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,572	2,240,787	0.022123	4,796	106	52.00
53.00	05300	ANESTHESIOLOGY	59,277	1,222,931	0.048471	63,233	3,065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,226,701	33,391,647	0.036737	473,409	17,392	54.00
60.00	06000	LABORATORY	496,520	14,798,025	0.033553	811,758	27,237	60.00
65.00	06500	RESPIRATORY THERAPY	96,305	2,240,223	0.042989	288,149	12,387	65.00
66.00	06600	PHYSICAL THERAPY	439,178	5,172,292	0.084910	175,899	14,936	66.00
68.00	06800	SPEECH PATHOLOGY	10,083	281,033	0.035878	29,355	1,053	68.00
69.00	06900	ELECTROCARDIOLOGY	34,489	1,782,868	0.019345	187,726	3,632	69.00
69.01	06902	CARDIAC REHABILITATION	286,822	790,278	0.362938	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,642	2,054,145	0.007128	437,395	3,118	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,770	1,824,243	0.020704	426,395	8,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	138,234	9,905,771	0.013955	874,841	12,208	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	624,360	13,020,376	0.047953	1,108	53	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	147,435	726,035	0.203069	0	0	92.00
200.00		Total (lines 50-199)	4,799,267	96,608,891		4,033,050	145,184	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06902	CARDIAC REHABILITATION	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,158,237	0.000000	0.000000	258,986	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,240,787	0.000000	0.000000	4,796	52.00
53.00	05300	ANESTHESIOLOGY	0	1,222,931	0.000000	0.000000	63,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,391,647	0.000000	0.000000	473,409	54.00
60.00	06000	LABORATORY	0	14,798,025	0.000000	0.000000	811,758	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,240,223	0.000000	0.000000	288,149	65.00
66.00	06600	PHYSICAL THERAPY	0	5,172,292	0.000000	0.000000	175,899	66.00
68.00	06800	SPEECH PATHOLOGY	0	281,033	0.000000	0.000000	29,355	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,782,868	0.000000	0.000000	187,726	69.00
69.01	06902	CARDIAC REHABILITATION	0	790,278	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,054,145	0.000000	0.000000	437,395	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,824,243	0.000000	0.000000	426,395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,905,771	0.000000	0.000000	874,841	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	13,020,376	0.000000	0.000000	1,108	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	726,035	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	96,608,891			4,033,050	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06902	CARDIAC REHABILITATION	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.593814	0	1,903,217	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.129845	0	3,422	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.381131	0	220,352	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141367	0	9,797,564	0	0	54.00
60.00	06000	LABORATORY	0.248683	0	3,919,980	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.396201	0	424,955	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.604119	0	1,223,765	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.551352	0	17,266	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184910	0	512,618	0	0	69.00
69.01	06902	CARDIAC REHABILITATION	0.874148	0	408,242	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102908	0	273,071	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298912	0	273,089	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279677	0	4,070,974	3,132	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.343246	0	3,055,301	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.733865	0	349,718	0	0	92.00
200.00		Subtotal (see instructions)		0	26,453,534	3,132	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	26,453,534	3,132	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,130,157	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	444	0		52.00
53.00	05300	ANESTHESIOLOGY	83,983	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,385,052	0		54.00
60.00	06000	LABORATORY	974,832	0		60.00
65.00	06500	RESPIRATORY THERAPY	168,368	0		65.00
66.00	06600	PHYSICAL THERAPY	739,300	0		66.00
68.00	06800	SPEECH PATHOLOGY	9,520	0		68.00
69.00	06900	ELECTROCARDIOLOGY	94,788	0		69.00
69.01	06902	CARDIAC REHABILITATION	356,864	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,101	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,630	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,138,558	876		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,048,720	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	256,646	0		92.00
200.00		Subtotal (see instructions)	7,496,963	876		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,496,963	876		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.593814	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.129845	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.381131	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141367	0	0	0	0	54.00
60.00	06000	LABORATORY	0.248683	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.396201	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.604119	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.551352	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184910	0	0	0	0	69.00
69.01	06902	CARDIAC REHABILITATION	0.874148	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102908	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298912	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279677	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.343246	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.733865	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06902	CARDIAC REHABILITATION	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,488	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,675	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,389	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	164	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)	497	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	38	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)	114	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,523	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)	164	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)	493	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	138.58	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	142.73	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,099,424	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)	5,266	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)	16,271	25.00
26.00	Total swing-bed cost (see instructions)	1,252,967	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,846,457	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)	6,846,457	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,862.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,837,319	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,837,319	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	1,136,152	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,973,471	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)	305,529	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	918,449	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,223,978	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	286	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,862.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	532,812	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,894,499	6,846,457	0.276712	532,812	147,435	90.00
91.00	Nursing School cost	0	6,846,457	0.000000	532,812	0	91.00
92.00	Allied health cost	0	6,846,457	0.000000	532,812	0	92.00
93.00	All other Medical Education	0	6,846,457	0.000000	532,812	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,928,748		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.593814	258,986	153,790	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.129845	4,796	623	52.00
53.00	05300	ANESTHESIOLOGY	0.381131	63,233	24,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141367	473,409	66,924	54.00
60.00	06000	LABORATORY	0.248683	811,758	201,870	60.00
65.00	06500	RESPIRATORY THERAPY	0.396201	288,149	114,165	65.00
66.00	06600	PHYSICAL THERAPY	0.604119	175,899	106,264	66.00
68.00	06800	SPEECH PATHOLOGY	0.551352	29,355	16,185	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184910	187,726	34,712	69.00
69.01	06902	CARDIAC REHABILITATION	0.874148	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102908	437,395	45,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298912	426,395	127,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279677	874,841	244,673	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.343246	1,108	380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.733865	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,033,050	1,136,152	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		4,033,050		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.593814	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.129845	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.381131	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.141367	104,870	14,825	54.00
60.00	06000	LABORATORY	0.248683	189,258	47,065	60.00
65.00	06500	RESPIRATORY THERAPY	0.396201	94,211	37,326	65.00
66.00	06600	PHYSICAL THERAPY	0.604119	117,725	71,120	66.00
68.00	06800	SPEECH PATHOLOGY	0.551352	6,273	3,459	68.00
69.00	06900	ELECTROCARDIOLOGY	0.184910	17,549	3,245	69.00
69.01	06902	CARDIAC REHABILITATION	0.874148	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102908	126,052	12,972	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.298912	322,325	96,347	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279677	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.343246	914	314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.733865	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		979,177	286,673	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)		979,177		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141322	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/10/2016 2:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,497,839	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,497,839	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	7,572,817	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	43,298	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,557,470	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,972,049	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,972,049	30.00
31.00	Primary payer payments	824	31.00
32.00	Subtotal (line 30 minus line 31)	2,971,225	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	508,486	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	330,516	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	409,611	36.00
37.00	Subtotal (see instructions)	3,301,741	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,301,741	40.00
40.01	Sequestration adjustment (see instructions)	66,035	40.01
41.00	Interim payments	3,556,664	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-320,958	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,652,864		4,287,166	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	04/09/2015	15,196		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	09/15/2015	458,388	04/09/2015	9,889	3.50
3.51			0	09/15/2015	720,613	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-443,192		-730,502	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,209,672		3,556,664	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		357,933		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		320,958	6.02
7.00	Total Medicare program liability (see instructions)		3,567,605		3,235,706	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/10/2016 2:35 pm

Component CCN: 14Z322 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,244,343		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	04/09/2015	131,338		0	3.01
3.02		09/15/2015	402,667		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		534,005		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,778,348		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		298,948		0	6.02
7.00	Total Medicare program liability (see instructions)		1,479,400		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141322	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/10/2016 2:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,003	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,523	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	581	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,389	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	102,175,263	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,716,088	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141322 | Component CCN: 14Z322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-2 | Date/Time Prepared: 2/10/2016 2:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,236,218	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	289,540	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	657	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,525,758	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,525,758	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,525,758	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	16,166	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,509,592	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,509,592	0	19.00
19.01	Sequestration adjustment (see instructions)	30,192	0	19.01
20.00	Interim payments	1,778,348	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-298,948	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141322	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/10/2016 2:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,973,471	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,973,471	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,013,206	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,013,206	19.00
20.00	Deductibles (exclude professional component)	408,412	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,604,794	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,604,794	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	54,798	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	35,619	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,940	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,640,413	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,640,413	30.00
30.01	Sequestration adjustment (see instructions)	72,808	30.01
31.00	Interim payments	3,209,672	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	357,933	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/10/2016 2:35 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	27,840,817	0	0	0	1.00
2.00	Temporary investments	6,828,177	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,962,926	0	0	0	4.00
5.00	Other receivable	619,702	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,546,393	0	0	0	6.00
7.00	Inventory	503,922	0	0	0	7.00
8.00	Prepaid expenses	192,918	0	0	0	8.00
9.00	Other current assets	1,131,138	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)	42,533,207	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	834,848	0	0	0	12.00
13.00	Land improvements	5,976,844	0	0	0	13.00
14.00	Accumulated depreciation	-2,297,887	0	0	0	14.00
15.00	Buildings	42,367,863	0	0	0	15.00
16.00	Accumulated depreciation	-12,245,614	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	15,708,959	0	0	0	23.00
24.00	Accumulated depreciation	-11,298,400	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	613,130	0	0	0	27.00
28.00	Accumulated depreciation	-227,155	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)	39,432,588	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	25,757,834	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	645,550	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26,403,384	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	108,369,179	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,264,298	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,357,391	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	127,849	0	0	0	40.00
41.00	Deferred income	1,131,138	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	4,460,543	0	0	0	43.00
44.00	Other current liabilities	480,224	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,821,443	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	41,890,464	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	41,890,464	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	50,711,907	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	57,657,272				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	57,657,272	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	108,369,179	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/10/2016 2:35 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		48,453,133		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,651,368				2.00
3.00	Total (sum of line 1 and line 2)		58,104,501		0		3.00
4.00	ROUNDING	17		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		17		0		10.00
11.00	Subtotal (line 3 plus line 10)		58,104,518		0		11.00
12.00	TRANSFER FROM AFFILIATES	447,246		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		447,246		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		57,657,272		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	ROUNDING		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	TRANSFER FROM AFFILIATES		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: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/10/2016 2:35 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,582,835		3,582,835	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	378,403		378,403	5.00
6.00	Swing bed - NF	87,015		87,015	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)	4,048,253		4,048,253	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)	4,048,253		4,048,253	17.00
18.00	Ancillary services	13,060,647	86,449,225	99,509,872	18.00
19.00	Outpatient services	0	50,800	50,800	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	NURSERY	377,460	0	377,460	27.00
27.01	PROFEES	676,383	9,889,268	10,565,651	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,162,743	96,389,293	114,552,036	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,880,132		29.00
30.00	PROVISION FOR BAD DEBTS	2,041,535			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)		2,041,535		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)		41,921,667		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141322 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/10/2016 2:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	114,552,036	1.00
2.00	Less contractual allowances and discounts on patients' accounts	66,884,953	2.00
3.00	Net patient revenues (line 1 minus line 2)	47,667,083	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,921,667	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,745,416	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	255,599	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	142,699	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	1,321	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	3,850,466	23.00
24.00	MISCELLANEOUS INCOME	-491,040	24.00
24.01	MEANINGFUL USE INCOME	126,337	24.01
24.02	MANAGEMENT SUPPORT	15,600	24.02
25.00	Total other income (sum of lines 6-24)	3,900,982	25.00
26.00	Total (line 5 plus line 25)	9,646,398	26.00
27.00	SALE OF REFUSE	-4,972	27.00
27.01	ROUNDING	2	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-4,970	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,651,368	29.00