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: 141339	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/24/2016 1:57 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/24/2016 Time: 1:57 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TAYLORVILLE MEMORIAL HOSPITAL (141339) 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	580,500	1,787,121	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	-999,115	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	-418,615	1,787,121	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2016 1:42 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 EAST PLEASANT STREET	PO Box:			1.00
2.00	City: TAYLORVILLE	State: IL	Zip Code: 62568	County: CHRISTIAN	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	TAYLORVILLE MEMORIAL HOSPITAL	141339	99914	1	09/01/2004	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	TAYLORVILLE MEMORIAL-SWB	14Z339	99914		09/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	TAYLORVILLE SKILLED NURSING FACILITY	145539	99914		07/01/1966	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 1:42 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 1:42 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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 1:42 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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	69,307	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/24/2016 1:42 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	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 HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	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: 141339	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 1:42 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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2016 1:42 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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/24/2016 1:42 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.	BKD, LLP	BKD, LLP	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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/24/2016 1:42 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.		BKD, LLP		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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/24/2016 1:42 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	90,343.00	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	90,343.00	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						13.00
14.00	Total (see instructions)		25	9,125	90,343.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	2,860		0	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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2016 1:42 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)	2,650	62	3,781			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,564	0	1,620			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	493			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,214	62	5,894			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)	4,214	62	5,894	0.00	285.92	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	1,020	0	1,306	0.00	7.19	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	293.11	27.00
28.00	Observation Bed Days		0	258			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			18			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/24/2016 1:42 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	701	22	1,063	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	701	22	1,063	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/24/2016 1:42 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	09/01/2004	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/24/2016 1:42 pm

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

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	102,952			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/24/2016 1:42 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)	0.381372	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,052,029	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	2,469,452	5.00
6.00	Medicaid charges	10,350,733	6.00
7.00	Medicaid cost (line 1 times line 6)	3,947,480	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	352,360	1,510,423	1,862,783	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	134,380	576,033	710,413	21.00
22.00	Partial payment by patients approved for charity care	37,039	0	37,039	22.00
23.00	Cost of charity care (line 21 minus line 22)	97,341	576,033	673,374	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)	1,315,451	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	444,884	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	870,567	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	332,010	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,005,384	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,005,384	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,595,889	1,595,889	955,942	2,551,831	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,550,452	1,550,452	101,791	1,652,243	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	127,372	3,776,112	3,903,484	397,435	4,300,919	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,137,563	4,904,614	7,042,177	-426,508	6,615,669	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	769,860	1,446,460	2,216,320	0	2,216,320	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,540	62,528	151,068	0	151,068	8.00
9.00	00900	HOUSEKEEPING	386,818	99,640	486,458	0	486,458	9.00
10.00	01000	DIETARY	458,776	470,957	929,733	-650,906	278,827	10.00
11.00	01100	CAFETERIA	0	0	0	650,906	650,906	11.00
13.00	01300	NURSING ADMINISTRATION	477,341	67,655	544,996	0	544,996	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	49,398	201,532	250,930	0	250,930	14.00
15.00	01500	PHARMACY	403,871	1,150,181	1,554,052	-1,102,687	451,365	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	489,215	60,818	550,033	0	550,033	16.00
17.00	01700	SOCIAL SERVICE	48,787	3,425	52,212	0	52,212	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,237,509	297,100	2,534,609	0	2,534,609	30.00
44.00	04400	SKILLED NURSING FACILITY	210,679	167,746	378,425	-167,193	211,232	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	591,504	705,623	1,297,127	-390,671	906,456	50.00
53.00	05300	ANESTHESIOLOGY	603,968	307,600	911,568	-5,316	906,252	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,046,244	741,306	1,787,550	-1,780	1,785,770	54.00
60.00	06000	LABORATORY	911,391	1,128,250	2,039,641	-65	2,039,576	60.00
65.00	06500	RESPIRATORY THERAPY	469,631	150,583	620,214	-56,689	563,525	65.00
66.00	06600	PHYSICAL THERAPY	1,002,426	280,742	1,283,168	0	1,283,168	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	167,193	167,193	66.01
68.00	06800	SPEECH PATHOLOGY	147,423	12,122	159,545	0	159,545	68.00
69.00	06900	ELECTROCARDIOLOGY	134,269	52,915	187,184	0	187,184	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34,994	49,074	84,068	273,940	358,008	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	223,239	223,239	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,103,642	1,103,642	73.00
76.00	03020	OP PSYCH	113,123	168,710	281,833	0	281,833	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,599,360	2,442,773	4,042,133	-43,613	3,998,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,028,660	1,028,660	-1,028,660	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,540,062	22,923,467	37,463,529	0	37,463,529	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	829	1,253	2,082	0	2,082	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	14,540,891	22,924,720	37,465,611	0	37,465,611	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/24/2016 1:42 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	-70,877	2,480,954		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	20,188	1,672,431		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-57,018	4,243,901		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-572,686	6,042,983		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	2,216,320		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	151,068		8.00
9.00	00900	HOUSEKEEPING	0	486,458		9.00
10.00	01000	DIETARY	0	278,827		10.00
11.00	01100	CAFETERIA	-194,097	456,809		11.00
13.00	01300	NURSING ADMINISTRATION	0	544,996		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	250,930		14.00
15.00	01500	PHARMACY	0	451,365		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,637	539,396		16.00
17.00	01700	SOCIAL SERVICE	0	52,212		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,534,609		30.00
44.00	04400	SKILLED NURSING FACILITY	0	211,232		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	906,456		50.00
53.00	05300	ANESTHESIOLOGY	-699,468	206,784		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,736	1,788,506		54.00
60.00	06000	LABORATORY	0	2,039,576		60.00
65.00	06500	RESPIRATORY THERAPY	0	563,525		65.00
66.00	06600	PHYSICAL THERAPY	0	1,283,168		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	167,193		66.01
68.00	06800	SPEECH PATHOLOGY	0	159,545		68.00
69.00	06900	ELECTROCARDIOLOGY	-35,923	151,261		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	358,008		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	223,239		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,103,642		73.00
76.00	03020	OP PSYCH	0	281,833		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-2,035,411	1,963,109		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)	-3,653,193	33,810,336		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,082		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,653,193	33,812,418		200.00

RECLASSIFICATIONS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/24/2016 1:42 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS CAFETERIA EXPENSES				
1.00	CAFETERIA	11.00	321,189	329,717	1.00
	0		321,189	329,717	
	B - TO RECLASS BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,103,642	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	1,103,642	
	C - RECLASS PENSION COSTS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	397,435	1.00
	0		0	397,435	
	D - TO RECLASS BILLABLE SUPPLIES/IMPLANT				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	273,940	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	232,101	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	506,041	
	E - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	29,073	1.00
	0		0	29,073	
	F - TO RECLASS SNF THERAPY EXPENSE				
1.00	PHYSICAL THERAPY SNF	66.01	0	167,193	1.00
	0		0	167,193	
	G - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	939,909	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	88,751	2.00
	0		0	1,028,660	
500.00	Grand Total: Increases		321,189	3,561,761	500.00

RECLASSIFICATIONS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/24/2016 1:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA EXPENSES						
1.00	DIETARY	10.00	321,189	329,717	0		1.00
	0		321,189	329,717			
	B - TO RECLASS BILLABLE DRUGS						
1.00	PHARMACY	15.00	0	1,102,687	0		1.00
2.00	OPERATING ROOM	50.00	0	243	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	519	0		3.00
4.00	LABORATORY	60.00	0	65	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	128	0		5.00
	0		0	1,103,642			
	C - RECLASS PENSION COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	397,435	0		1.00
	0		0	397,435			
	D - TO RECLASS BILLABLE SUPPLIES/IMPLANT						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,862	0		1.00
2.00	OPERATING ROOM	50.00	0	390,428	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	4,797	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,780	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	56,561	0		5.00
6.00	EMERGENCY	91.00	0	43,613	0		6.00
	0		0	506,041			
	E - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,073	0		1.00
	0		0	29,073			
	F - TO RECLASS SNF THERAPY EXPENSE						
1.00	SKILLED NURSING FACILITY	44.00	0	167,193	0		1.00
	0		0	167,193			
	G - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,028,660	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,028,660			
500.00	Grand Total: Decreases		321,189	3,561,761			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/24/2016 1:42 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	737,345	5,725	0	5,725	0	1.00
2.00	Land Improvements	3,419,907	29,320	0	29,320	750	2.00
3.00	Buildings and Fixtures	24,867,602	325,512	0	325,512	12,511	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	21,054,416	1,023,834	0	1,023,834	338,125	6.00
7.00	HIT designated Assets	2,150,395	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,229,665	1,384,391	0	1,384,391	351,386	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,229,665	1,384,391	0	1,384,391	351,386	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	743,070	0	1.00
2.00	Land Improvements	3,448,477	0	2.00
3.00	Buildings and Fixtures	25,180,603	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	21,740,125	0	6.00
7.00	HIT designated Assets	2,150,395	0	7.00
8.00	Subtotal (sum of lines 1-7)	53,262,670	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	53,262,670	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/24/2016 1:42 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,595,889	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,550,452	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,146,341	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,595,889		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,550,452		2.00
3.00	Total (sum of lines 1-2)	0	3,146,341		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/24/2016 1:42 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	29,372,150	0	29,372,150	0.551458	16,033	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,890,520	0	23,890,520	0.448542	13,040	2.00
3.00	Total (sum of lines 1-2)	53,262,670	0	53,262,670	1.000000	29,073	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	16,033	1,602,918	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,040	1,578,479	0	2.00
3.00	Total (sum of lines 1-2)	0	0	29,073	3,181,397	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	862,003	16,033	0	0	2,480,954	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	80,912	13,040	0	0	1,672,431	2.00
3.00	Total (sum of lines 1-2)	942,915	29,073	0	0	4,153,385	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/24/2016 1:42 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	-77,906	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-7,839	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-1,402	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-2,920	ADMINISTRATIVE & GENERAL	5.00	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	-2,068,598			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	532,596			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-194,097	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	-10,637	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	-125,042	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	PROVIDER TAX EXPENSE	A	-709,370	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	CRNA CONTRACT EXPENSE	A	-71,945	ANESTHESIOLOGY	53.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/24/2016 1:42 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	
33.02	CRNA SALARY EXPENSE	A	-603,968	ANESTHESIOLOGY	53.00	0	33.02
33.03	CRNA FICA EXPENSE	A	-23,555	ANESTHESIOLOGY	53.00	0	33.03
33.04	CRNA BENEFIT EXPENSE	A	-180,828	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING SALARY EXPENSE	A	-13,874	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MARKETING FICA EXPENSE	A	-924	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING BENEFIT EXPENSE	A	-4,154	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	ADVERTISING EXPENSE	A	-52,074	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	MARKETING OTHER EXPENSE	A	-7,934	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	LOBBYING EXPENSE	A	-20,739	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-6,760	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PHYSICIAN RECRUITMENT EXPENSE	A	-113	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	SALE OF REFUSE & JUNKSALE OF REFUSE	B	-1,110	ADMINISTRATIVE & GENERAL	5.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,653,193				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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 2/24/2016 1:42 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	CAPITAL BLDG HO BLDG CAPTIAL	7,029	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	153,069	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HO INTEREST (OPERATING)	15,873	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	A&G HO MANAGEMENT	2,344,737	2,100,858	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	2,593,882	2,465,805	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	A&G ITEMS - MMC	17,867	17,867	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	A&G PERSONNEL - ALMH	0	4,139	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	A&G PERSONNEL - VAN	0	11,192	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,132,457	4,599,861	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 HEALTH	100.00	6.00
7.00	B		0.00	MEMORIAL MD CTR	0.00	7.00
8.00	B		0.00	ABRAHAM LINCOLN	0.00	8.00
9.00	B		0.00	MEMORIAL VNA	0.00	9.00
10.00	B		0.00	PASSAVANT	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: 141339	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/24/2016 1:42 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	7,029	9		1.00
2.00	153,069	9		2.00
3.00	15,873	0		3.00
4.00	243,879	0		4.00
4.01	128,077	0		4.01
4.02	0	0		4.02
4.03	-4,139	0		4.03
4.04	-11,192	0		4.04
5.00	532,596			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	HOSPITAL		8.00
9.00	HOME HEALTH		9.00
10.00	HOSPITAL		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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/24/2016 1:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	3,318	0	3,318	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	1,320	0	1,320	0	0	2.00
3.00	50.00	OPERATING ROOM	10,400	0	10,400	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	185,443	0	185,443	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	5,134	-2,736	7,870	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	3,600	0	3,600	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	35,923	35,923	0	0	0	7.00
8.00	91.00	EMERGENCY	2,202,347	2,035,411	166,936	0	0	8.00
9.00	76.00	OP PSYCH	157,943	0	154,943	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,605,428	2,068,598	533,830		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	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	54.00	RADIOLOGY-DIAGNOSTIC	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	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	76.00	OP PSYCH	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	44.00	SKILLED NURSING FACILITY	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	-2,736		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	35,923		7.00
8.00	91.00	EMERGENCY	0	0	0	2,035,411		8.00
9.00	76.00	OP PSYCH	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,068,598		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,480,954	2,480,954				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,672,431		1,672,431			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,243,901	6,260	0	4,250,161		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,042,983	433,153	386,192	656,675	7,519,003	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	117,302	0	0	117,302	6.00
7.00	00700	OPERATION OF PLANT	2,216,320	671,496	47,141	237,019	3,171,976	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	151,068	13,592	0	27,259	191,919	8.00
9.00	00900	HOUSEKEEPING	486,458	49,600	251	119,091	655,400	9.00
10.00	01000	DIETARY	278,827	94,840	7,767	43,080	424,514	10.00
11.00	01100	CAFETERIA	456,809	36,446	4,264	98,165	595,684	11.00
13.00	01300	NURSING ADMINISTRATION	544,996	51,863	1,817	146,960	745,636	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	250,930	27,002	47,970	15,208	341,110	14.00
15.00	01500	PHARMACY	451,365	17,770	15,586	124,341	609,062	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	539,396	60,914	1,829	150,616	752,755	16.00
17.00	01700	SOCIAL SERVICE	52,212	4,510	0	15,020	71,742	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,534,609	220,469	26,826	688,864	3,470,768	30.00
44.00	04400	SKILLED NURSING FACILITY	211,232	47,352	0	64,862	323,446	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	906,456	135,343	144,899	182,108	1,368,806	50.00
53.00	05300	ANESTHESIOLOGY	206,784	12,928	44,286	0	263,998	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,788,506	101,915	751,605	322,110	2,964,136	54.00
60.00	06000	LABORATORY	2,039,576	51,878	51,287	280,593	2,423,334	60.00
65.00	06500	RESPIRATORY THERAPY	563,525	45,210	11,305	144,587	764,627	65.00
66.00	06600	PHYSICAL THERAPY	1,283,168	68,863	15,314	308,620	1,675,965	66.00
66.01	06601	PHYSICAL THERAPY SNF	167,193	0	0	0	167,193	66.01
68.00	06800	SPEECH PATHOLOGY	159,545	4,722	0	45,388	209,655	68.00
69.00	06900	ELECTROCARDIOLOGY	151,261	18,947	6,802	41,338	218,348	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	358,008	0	0	10,774	368,782	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	223,239	0	0	0	223,239	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,103,642	0	0	0	1,103,642	73.00
76.00	03020	OP PSYCH	281,833	23,638	0	34,828	340,299	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,963,109	125,086	107,078	492,400	2,687,673	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)	33,810,336	2,441,099	1,672,219	4,249,906	33,770,014	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,775	0	0	9,775	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,082	30,080	212	255	32,629	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	33,812,418	2,480,954	1,672,431	4,250,161	33,812,418	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,519,003					5.00
6.00	00600	MAINTENANCE & REPAIRS	33,544	150,846				6.00
7.00	00700	OPERATION OF PLANT	907,074	109,823	4,188,873			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,882	2,560	45,447	294,808		8.00
9.00	00900	HOUSEKEEPING	187,421	458	165,850	13,622	1,022,751	9.00
10.00	01000	DIETARY	121,396	2,538	317,123	1,429	0	10.00
11.00	01100	CAFETERIA	170,345	0	121,865	2,086	9,385	11.00
13.00	01300	NURSING ADMINISTRATION	213,226	320	173,416	0	75,528	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,546	2,473	90,289	983	5,810	14.00
15.00	01500	PHARMACY	174,170	349	59,420	0	12,737	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	215,262	567	203,681	0	14,525	16.00
17.00	01700	SOCIAL SERVICE	20,516	0	15,082	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	992,524	7,687	737,195	111,991	277,975	30.00
44.00	04400	SKILLED NURSING FACILITY	92,494	1,062	158,334	42,902	48,043	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	391,431	3,054	452,557	22,295	99,437	50.00
53.00	05300	ANESTHESIOLOGY	75,494	276	43,228	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	847,639	909	340,779	18,935	62,344	54.00
60.00	06000	LABORATORY	692,989	2,065	173,467	621	61,450	60.00
65.00	06500	RESPIRATORY THERAPY	218,657	1,731	151,172	6,154	24,357	65.00
66.00	06600	PHYSICAL THERAPY	479,267	836	230,263	21,025	47,819	66.00
66.01	06601	PHYSICAL THERAPY SNF	47,811	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	59,954	29	15,788	0	5,810	68.00
69.00	06900	ELECTROCARDIOLOGY	62,440	422	63,354	0	5,810	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,459	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,839	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	315,603	0	0	0	0	73.00
76.00	03020	OP PSYCH	97,314	116	79,041	0	9,609	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	768,580	6,138	418,257	47,840	251,163	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)	7,506,877	143,413	4,055,608	289,883	1,011,802	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,795	44	32,686	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,331	7,389	100,579	4,925	10,949	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	7,519,003	150,846	4,188,873	294,808	1,022,751	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	867,000					10.00
11.00	01100	CAFETERIA	0	899,365				11.00
13.00	01300	NURSING ADMINISTRATION	0	29,683	1,237,809			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,801	37,613	584,625		14.00
15.00	01500	PHARMACY	0	27,569	0	0	883,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	65,794	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,379	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	731,292	214,875	594,005	18,077	0	30.00
44.00	04400	SKILLED NURSING FACILITY	121,289	34,622	69,965	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,532	120,331	67,416	195	50.00
53.00	05300	ANESTHESIOLOGY	0	9,729	0	4,655	415	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	90,644	0	37,343	0	54.00
60.00	06000	LABORATORY	0	85,251	0	243,351	52	60.00
65.00	06500	RESPIRATORY THERAPY	0	41,935	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	74,832	0	3,139	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	9,017	0	532	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,613	6,501	1,239	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	108,576	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	88,895	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	882,645	73.00
76.00	03020	OP PSYCH	0	11,972	33,121	200	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	136,052	376,087	11,010	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)	852,581	899,300	1,237,623	584,433	883,307	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	65	186	192	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	14,419	0	0	0	0	194.00
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)	867,000	899,365	1,237,809	584,625	883,307	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,252,584					16.00
17.00	01700	SOCIAL SERVICE	0	111,719				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	414,109	104,844	7,675,342	0	7,675,342	30.00
44.00	04400	SKILLED NURSING FACILITY	18,590	6,875	917,622	0	917,622	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,578	0	2,654,632	0	2,654,632	50.00
53.00	05300	ANESTHESIOLOGY	0	0	397,795	0	397,795	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	130,771	0	4,493,500	0	4,493,500	54.00
60.00	06000	LABORATORY	77,565	0	3,760,145	0	3,760,145	60.00
65.00	06500	RESPIRATORY THERAPY	21,795	0	1,230,428	0	1,230,428	65.00
66.00	06600	PHYSICAL THERAPY	11,218	0	2,544,364	0	2,544,364	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	215,004	0	215,004	66.01
68.00	06800	SPEECH PATHOLOGY	321	0	301,106	0	301,106	68.00
69.00	06900	ELECTROCARDIOLOGY	19,872	0	388,599	0	388,599	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	582,817	0	582,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	375,973	0	375,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,301,890	0	2,301,890	73.00
76.00	03020	OP PSYCH	0	0	571,672	0	571,672	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	466,355	0	5,169,155	0	5,169,155	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)	1,246,174	111,719	33,580,044	0	33,580,044	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	45,300	0	45,300	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,410	0	172,655	0	172,655	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	14,419	0	14,419	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,252,584	111,719	33,812,418	0	33,812,418	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/24/2016 1:42 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	6,260	0	6,260	6,260	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	61,352	433,153	386,192	880,697	966	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	117,302	0	117,302	0	6.00
7.00	00700	OPERATION OF PLANT	0	671,496	47,141	718,637	349	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,592	0	13,592	40	8.00
9.00	00900	HOUSEKEEPING	0	49,600	251	49,851	175	9.00
10.00	01000	DIETARY	0	94,840	7,767	102,607	63	10.00
11.00	01100	CAFETERIA	0	36,446	4,264	40,710	144	11.00
13.00	01300	NURSING ADMINISTRATION	0	51,863	1,817	53,680	216	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,002	47,970	74,972	22	14.00
15.00	01500	PHARMACY	0	17,770	15,586	33,356	183	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,914	1,829	62,743	222	16.00
17.00	01700	SOCIAL SERVICE	0	4,510	0	4,510	22	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,648	220,469	26,826	249,943	1,021	30.00
44.00	04400	SKILLED NURSING FACILITY	1,224	47,352	0	48,576	95	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	135,343	144,899	280,242	268	50.00
53.00	05300	ANESTHESIOLOGY	0	12,928	44,286	57,214	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	101,915	751,605	853,520	474	54.00
60.00	06000	LABORATORY	0	51,878	51,287	103,165	413	60.00
65.00	06500	RESPIRATORY THERAPY	540	45,210	11,305	57,055	213	65.00
66.00	06600	PHYSICAL THERAPY	0	68,863	15,314	84,177	454	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	4,722	0	4,722	67	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,947	6,802	25,749	61	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,128	0	0	2,128	16	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	03020	OP PSYCH	0	23,638	0	23,638	51	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	125,086	107,078	232,164	725	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)	67,892	2,441,099	1,672,219	4,181,210	6,260	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,775	0	9,775	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,080	212	30,292	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	67,892	2,480,954	1,672,431	4,221,277	6,260	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	881,663					5.00
6.00	00600	MAINTENANCE & REPAIRS	3,933	121,235				6.00
7.00	00700	OPERATION OF PLANT	106,363	88,265	913,614			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,435	2,057	9,912	32,036		8.00
9.00	00900	HOUSEKEEPING	21,977	368	36,173	1,480	110,024	9.00
10.00	01000	DIETARY	14,235	2,040	69,166	155	0	10.00
11.00	01100	CAFETERIA	19,974	0	26,579	227	1,010	11.00
13.00	01300	NURSING ADMINISTRATION	25,003	257	37,823	0	8,125	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,438	1,987	19,693	107	625	14.00
15.00	01500	PHARMACY	20,423	281	12,960	0	1,370	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,241	456	44,424	0	1,562	16.00
17.00	01700	SOCIAL SERVICE	2,406	0	3,289	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,376	6,178	160,786	12,169	29,904	30.00
44.00	04400	SKILLED NURSING FACILITY	10,846	853	34,533	4,662	5,168	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,899	2,455	98,705	2,423	10,697	50.00
53.00	05300	ANESTHESIOLOGY	8,852	222	9,428	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,393	731	74,326	2,058	6,707	54.00
60.00	06000	LABORATORY	81,259	1,660	37,834	67	6,611	60.00
65.00	06500	RESPIRATORY THERAPY	25,639	1,391	32,971	669	2,620	65.00
66.00	06600	PHYSICAL THERAPY	56,198	672	50,222	2,285	5,144	66.00
66.01	06601	PHYSICAL THERAPY SNF	5,606	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	7,030	23	3,443	0	625	68.00
69.00	06900	ELECTROCARDIOLOGY	7,322	339	13,818	0	625	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,366	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,486	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,007	0	0	0	0	73.00
76.00	03020	OP PSYCH	11,411	94	17,239	0	1,034	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	90,123	4,933	91,224	5,199	27,019	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)	880,241	115,262	884,548	31,501	108,846	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	328	35	7,129	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,094	5,938	21,937	535	1,178	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	881,663	121,235	913,614	32,036	110,024	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	188,266					10.00
11.00	01100	CAFETERIA	0	88,644				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,926	128,030			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	867	3,890	113,601		14.00
15.00	01500	PHARMACY	0	2,717	0	0	71,290	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,485	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	432	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	158,798	21,178	61,440	3,513	0	30.00
44.00	04400	SKILLED NURSING FACILITY	26,337	3,412	7,237	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,291	12,446	13,100	16	50.00
53.00	05300	ANESTHESIOLOGY	0	959	0	904	34	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,934	0	7,256	0	54.00
60.00	06000	LABORATORY	0	8,403	0	47,287	4	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,133	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,376	0	610	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	889	0	103	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,046	672	241	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	21,098	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,274	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	71,236	73.00
76.00	03020	OP PSYCH	0	1,180	3,426	39	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	13,410	38,900	2,139	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)	185,135	88,638	128,011	113,564	71,290	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	6	19	37	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	3,131	0	0	0	0	194.00
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)	188,266	88,644	128,030	113,601	71,290	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	141,133					16.00
17.00	01700	SOCIAL SERVICE	0	10,659				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,659	10,003	877,968	0	877,968	30.00
44.00	04400	SKILLED NURSING FACILITY	2,095	656	144,470	0	144,470	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,642	0	480,184	0	480,184	50.00
53.00	05300	ANESTHESIOLOGY	0	0	77,613	0	77,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,734	0	1,068,133	0	1,068,133	54.00
60.00	06000	LABORATORY	8,740	0	295,443	0	295,443	60.00
65.00	06500	RESPIRATORY THERAPY	2,456	0	127,147	0	127,147	65.00
66.00	06600	PHYSICAL THERAPY	1,264	0	208,402	0	208,402	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	5,606	0	5,606	66.01
68.00	06800	SPEECH PATHOLOGY	36	0	16,938	0	16,938	68.00
69.00	06900	ELECTROCARDIOLOGY	2,239	0	52,112	0	52,112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	35,608	0	35,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,760	0	24,760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	108,243	0	108,243	73.00
76.00	03020	OP PSYCH	0	0	58,112	0	58,112	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	52,546	0	558,382	0	558,382	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)	140,411	10,659	4,139,121	0	4,139,121	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,267	0	17,267	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	722	0	61,758	0	61,758	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	3,131	0	3,131	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	141,133	10,659	4,221,277	0	4,221,277	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/24/2016 1:42 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	164,464					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,659,416				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	415	0	13,804,930			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,714	383,187	2,132,942	-7,519,003	26,293,415	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,776	0	0	0	117,302	6.00
7.00	00700	OPERATION OF PLANT	44,514	46,774	769,860	0	3,171,976	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	901	0	88,540	0	191,919	8.00
9.00	00900	HOUSEKEEPING	3,288	249	386,818	0	655,400	9.00
10.00	01000	DIETARY	6,287	7,707	139,927	0	424,514	10.00
11.00	01100	CAFETERIA	2,416	4,231	318,849	0	595,684	11.00
13.00	01300	NURSING ADMINISTRATION	3,438	1,803	477,341	0	745,636	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,790	47,597	49,398	0	341,110	14.00
15.00	01500	PHARMACY	1,178	15,465	403,871	0	609,062	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,038	1,815	489,215	0	752,755	16.00
17.00	01700	SOCIAL SERVICE	299	0	48,787	0	71,742	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,615	26,617	2,237,509	0	3,470,768	30.00
44.00	04400	SKILLED NURSING FACILITY	3,139	0	210,679	0	323,446	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,972	143,771	591,504	0	1,368,806	50.00
53.00	05300	ANESTHESIOLOGY	857	43,941	0	0	263,998	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,756	745,755	1,046,244	0	2,964,136	54.00
60.00	06000	LABORATORY	3,439	50,888	911,391	0	2,423,334	60.00
65.00	06500	RESPIRATORY THERAPY	2,997	11,217	469,631	0	764,627	65.00
66.00	06600	PHYSICAL THERAPY	4,565	15,195	1,002,426	0	1,675,965	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	167,193	66.01
68.00	06800	SPEECH PATHOLOGY	313	0	147,423	0	209,655	68.00
69.00	06900	ELECTROCARDIOLOGY	1,256	6,749	134,269	0	218,348	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	34,994	0	368,782	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	223,239	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,103,642	73.00
76.00	03020	OP PSYCH	1,567	0	113,123	0	340,299	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,292	106,245	1,599,360	0	2,687,673	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)	161,822	1,659,206	13,804,101	-7,519,003	26,251,011	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	648	0	0	0	9,775	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,994	210	829	0	32,629	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	2,480,954	1,672,431	4,250,161		7,519,003	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.085089	1.007843	0.307873		0.285965	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,260		881,663	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000453		0.033532	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	MAINTENANCE & REPAIRS (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	20,742					6.00
7.00	00700	OPERATION OF PLANT	15,101	83,045				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	352	901	305,684			8.00
9.00	00900	HOUSEKEEPING	63	3,288	14,125	4,577		9.00
10.00	01000	DIETARY	349	6,287	1,482	0	28,021	10.00
11.00	01100	CAFETERIA	0	2,416	2,163	42	0	11.00
13.00	01300	NURSING ADMINISTRATION	44	3,438	0	338	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	340	1,790	1,019	26	0	14.00
15.00	01500	PHARMACY	48	1,178	0	57	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78	4,038	0	65	0	16.00
17.00	01700	SOCIAL SERVICE	0	299	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,057	14,615	116,121	1,244	23,635	30.00
44.00	04400	SKILLED NURSING FACILITY	146	3,139	44,485	215	3,920	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	420	8,972	23,117	445	0	50.00
53.00	05300	ANESTHESIOLOGY	38	857	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125	6,756	19,634	279	0	54.00
60.00	06000	LABORATORY	284	3,439	644	275	0	60.00
65.00	06500	RESPIRATORY THERAPY	238	2,997	6,381	109	0	65.00
66.00	06600	PHYSICAL THERAPY	115	4,565	21,801	214	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	4	313	0	26	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58	1,256	0	26	0	69.00
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	03020	OP PSYCH	16	1,567	0	43	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	844	8,292	49,605	1,124	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)	19,720	80,403	300,577	4,528	27,555	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6	648	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,016	1,994	5,107	49	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	466	194.00
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)	150,846	4,188,873	294,808	1,022,751	867,000	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.272491	50.441002	0.964421	223.454446	30.941080	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	121,235	913,614	32,036	110,024	188,266	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.844904	11.001433	0.104801	24.038453	6.718747	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	41,692					11.00
13.00	01300	NURSING ADMINISTRATION	1,376	193,442				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	408	5,878	1,526,428			14.00
15.00	01500	PHARMACY	1,278	0	0	1,103,514		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,050	0	0	0	3,908	16.00
17.00	01700	SOCIAL SERVICE	203	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,961	92,830	47,197	0	1,292	30.00
44.00	04400	SKILLED NURSING FACILITY	1,605	10,934	0	0	58	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,018	18,805	176,020	243	267	50.00
53.00	05300	ANESTHESIOLOGY	451	0	12,153	519	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,202	0	97,500	0	408	54.00
60.00	06000	LABORATORY	3,952	0	635,382	65	242	60.00
65.00	06500	RESPIRATORY THERAPY	1,944	0	0	0	68	65.00
66.00	06600	PHYSICAL THERAPY	3,469	0	8,197	0	35	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	418	0	1,389	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	492	1,016	3,235	0	62	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	283,486	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	232,101	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,102,687	0	73.00
76.00	03020	OP PSYCH	555	5,176	521	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,307	58,774	28,747	0	1,455	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)	41,689	193,413	1,525,928	1,103,514	3,888	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	3	29	500	0	20	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	899,365	1,237,809	584,625	883,307	1,252,584	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.571644	6.398864	0.383002	0.800449	320.517912	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	88,644	128,030	113,601	71,290	141,133	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.126163	0.661852	0.074423	0.064603	36.113869	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/24/2016 1:42 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			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	2,080		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,952		30.00
44.00	04400	SKILLED NURSING FACILITY	128		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	06000	LABORATORY	0		60.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0		66.01
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	OP PSYCH	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	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)	2,080		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0		194.00
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)	111,719		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	53.711058		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,659		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.124519		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/24/2016 1:42 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	7,675,342		7,675,342	0	7,675,342	30.00
44.00	04400	SKILLED NURSING FACILITY	917,622		917,622	0	917,622	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,654,632		2,654,632	0	2,654,632	50.00
53.00	05300	ANESTHESIOLOGY	397,795		397,795	0	397,795	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,493,500		4,493,500	0	4,493,500	54.00
60.00	06000	LABORATORY	3,760,145		3,760,145	0	3,760,145	60.00
65.00	06500	RESPIRATORY THERAPY	1,230,428	0	1,230,428	0	1,230,428	65.00
66.00	06600	PHYSICAL THERAPY	2,544,364	0	2,544,364	0	2,544,364	66.00
66.01	06601	PHYSICAL THERAPY SNF	215,004	0	215,004	0	215,004	66.01
68.00	06800	SPEECH PATHOLOGY	301,106	0	301,106	0	301,106	68.00
69.00	06900	ELECTROCARDIOLOGY	388,599		388,599	0	388,599	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	582,817		582,817	0	582,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	375,973		375,973	0	375,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,301,890		2,301,890	0	2,301,890	73.00
76.00	03020	OP PSYCH	571,672		571,672	0	571,672	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,169,155		5,169,155	0	5,169,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	346,902		346,902		346,902	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,926,946	0	33,926,946	0	33,926,946	200.00
201.00		Less Observation Beds	346,902		346,902		346,902	201.00
202.00		Total (see instructions)	33,580,044	0	33,580,044	0	33,580,044	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/24/2016 1:42 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	6,471,492		6,471,492			30.00
44.00	04400	SKILLED NURSING FACILITY	328,047		328,047			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	317,460	6,642,163	6,959,623	0.381433	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	106,017	715,162	821,179	0.484419	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,731,948	32,655,748	35,387,696	0.126979	0.000000	54.00
60.00	06000	LABORATORY	2,319,533	10,012,183	12,331,716	0.304917	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,505,239	1,893,915	3,399,154	0.361981	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,064,386	3,175,307	4,239,693	0.600129	0.000000	66.00
66.01	06601	PHYSICAL THERAPY SNF	963,531	0	963,531	0.223142	0.000000	66.01
68.00	06800	SPEECH PATHOLOGY	156,205	476,402	632,607	0.475976	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	321,928	1,855,659	2,177,587	0.178454	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	849,038	556,659	1,405,697	0.414611	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,668	933,015	991,683	0.379126	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,493,726	3,516,769	5,010,495	0.459414	0.000000	73.00
76.00	03020	OP PSYCH	0	398,702	398,702	1.433833	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	65,625	5,784,457	5,850,082	0.883604	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,885	676,840	681,725	0.508859	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,757,728	69,292,981	88,050,709			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	18,757,728	69,292,981	88,050,709			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/24/2016 1:42 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
66.01	06601	PHYSICAL THERAPY SNF	0.000000		66.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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	03020	OP PSYCH	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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/24/2016 1:42 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	480,184	6,959,623	0.068996	128,345	8,855	50.00
53.00	05300	ANESTHESIOLOGY	77,613	821,179	0.094514	54,426	5,144	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,068,133	35,387,696	0.030184	1,678,159	50,654	54.00
60.00	06000	LABORATORY	295,443	12,331,716	0.023958	1,291,060	30,931	60.00
65.00	06500	RESPIRATORY THERAPY	127,147	3,399,154	0.037405	783,395	29,303	65.00
66.00	06600	PHYSICAL THERAPY	208,402	4,239,693	0.049155	173,521	8,529	66.00
66.01	06601	PHYSICAL THERAPY SNF	5,606	963,531	0.005818	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	16,938	632,607	0.026775	80,835	2,164	68.00
69.00	06900	ELECTROCARDIOLOGY	52,112	2,177,587	0.023931	213,199	5,102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,608	1,405,697	0.025331	472,426	11,967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,760	991,683	0.024968	18,840	470	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,243	5,010,495	0.021603	656,139	14,175	73.00
76.00	03020	OP PSYCH	58,112	398,702	0.145753	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	558,382	5,850,082	0.095449	5,304	506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	56,082	681,725	0.082265	3,393	279	92.00
200.00		Total (lines 50-199)	3,172,765	81,251,170		5,559,042	168,079	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 1:42 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
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
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03020	OP PSYCH	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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 1:42 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	6,959,623	0.000000	0.000000	128,345	50.00
53.00	05300	ANESTHESIOLOGY	0	821,179	0.000000	0.000000	54,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,387,696	0.000000	0.000000	1,678,159	54.00
60.00	06000	LABORATORY	0	12,331,716	0.000000	0.000000	1,291,060	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,399,154	0.000000	0.000000	783,395	65.00
66.00	06600	PHYSICAL THERAPY	0	4,239,693	0.000000	0.000000	173,521	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	963,531	0.000000	0.000000	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	632,607	0.000000	0.000000	80,835	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,177,587	0.000000	0.000000	213,199	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,405,697	0.000000	0.000000	472,426	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	991,683	0.000000	0.000000	18,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,010,495	0.000000	0.000000	656,139	73.00
76.00	03020	OP PSYCH	0	398,702	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,850,082	0.000000	0.000000	5,304	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	681,725	0.000000	0.000000	3,393	92.00
200.00		Total (lines 50-199)	0	81,251,170			5,559,042	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 1:42 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
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
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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	03020	OP PSYCH	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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/24/2016 1:42 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	0.381433	0	2,982,599	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.484419	0	275,711	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126979	0	11,798,713	0	0	54.00
60.00	06000	LABORATORY	0.304917	0	3,666,086	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.361981	0	689,845	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.600129	0	1,008,989	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.223142	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.475976	0	30,276	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178454	0	812,874	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.414611	0	162,739	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.379126	0	539,456	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.459414	0	2,097,441	1,311	0	73.00
76.00	03020	OP PSYCH	1.433833	0	365,122	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.883604	0	1,666,005	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.508859	0	343,546	0	0	92.00
200.00		Subtotal (see instructions)		0	26,439,402	1,311	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	26,439,402	1,311	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/24/2016 1:42 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	1,137,662	0		50.00
53.00	05300	ANESTHESIOLOGY	133,560	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,498,189	0		54.00
60.00	06000	LABORATORY	1,117,852	0		60.00
65.00	06500	RESPIRATORY THERAPY	249,711	0		65.00
66.00	06600	PHYSICAL THERAPY	605,524	0		66.00
66.01	06601	PHYSICAL THERAPY SNF	0	0		66.01
68.00	06800	SPEECH PATHOLOGY	14,411	0		68.00
69.00	06900	ELECTROCARDIOLOGY	145,061	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,473	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	204,522	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	963,594	602		73.00
76.00	03020	OP PSYCH	523,524	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,472,089	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	174,816	0		92.00
200.00		Subtotal (see instructions)	8,307,988	602		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	8,307,988	602		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141339 | Component CCN: 14Z339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/24/2016 1:42 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	0.381433	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.484419	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126979	0	0	0	0	54.00
60.00	06000	LABORATORY	0.304917	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.361981	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.600129	0	0	0	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.223142	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.475976	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178454	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.414611	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.379126	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.459414	0	0	0	0	73.00
76.00	03020	OP PSYCH	1.433833	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.883604	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.508859	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: 141339 | Component CCN: 14Z339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/24/2016 1:42 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
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
66.01	06601	PHYSICAL THERAPY SNF	0	0		66.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	03020	OP PSYCH	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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 1:42 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
66.01	06601	PHYSICAL THERAPY SNF	0	0	0	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03020	OP PSYCH	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: 141339 | Component CCN: 145539 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 1:42 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,959,623	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	821,179	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,387,696	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	12,331,716	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,399,154	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,239,693	0.000000	0.000000	0	66.00
66.01	06601	PHYSICAL THERAPY SNF	0	963,531	0.000000	0.000000	0	66.01
68.00	06800	SPEECH PATHOLOGY	0	632,607	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,177,587	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,405,697	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	991,683	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,010,495	0.000000	0.000000	0	73.00
76.00	03020	OP PSYCH	0	398,702	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	5,850,082	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	681,725	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	81,251,170			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/24/2016 1:42 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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
66.01	06601	PHYSICAL THERAPY SNF	0	0	0		66.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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	03020	OP PSYCH	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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 1:42 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)	6,152	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,039	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)	3,781	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	405	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)	1,215	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	123	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)	370	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,650	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)	391	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)	1,173	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	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,675,342	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)	16,548	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)	49,780	25.00
26.00	Total swing-bed cost (see instructions)	2,244,564	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,430,778	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,430,778	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)	1,344.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,563,164	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)	3,563,164	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 1:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	1,657,177	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,220,341	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)	525,735	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,577,204	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	2,102,939	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)	258	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,344.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	346,902	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 1:42 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	877,968	5,430,778	0.161665	346,902	56,082	90.00
91.00	Nursing School cost	0	5,430,778	0.000000	346,902	0	91.00
92.00	Allied health cost	0	5,430,778	0.000000	346,902	0	92.00
93.00	All other Medical Education	0	5,430,778	0.000000	346,902	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141339 Component CCN: 145539	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/24/2016 1:42 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,306	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,306	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)	1,306	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,020	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	917,622	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	917,622	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)	917,622	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Component CCN: 145539 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/24/2016 1:42 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	917,622	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	702.62	71.00
72.00	Program routine service cost (line 9 x line 71)	716,672	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	716,672	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	716,672	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	716,672	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1

Component CCN: 145539 | Date/Time Prepared: 2/24/2016 1:42 pm

Title XVIII | Skilled Nursing Facility | PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/24/2016 1:42 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		3,446,343		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.381433	128,345	48,955	50.00
53.00	05300	ANESTHESIOLOGY	0.484419	54,426	26,365	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126979	1,678,159	213,091	54.00
60.00	06000	LABORATORY	0.304917	1,291,060	393,666	60.00
65.00	06500	RESPIRATORY THERAPY	0.361981	783,395	283,574	65.00
66.00	06600	PHYSICAL THERAPY	0.600129	173,521	104,135	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.223142	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.475976	80,835	38,476	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178454	213,199	38,046	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.414611	472,426	195,873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.379126	18,840	7,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.459414	656,139	301,439	73.00
76.00	03020	OP PSYCH	1.433833	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.883604	5,304	4,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.508859	3,393	1,727	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,559,042	1,657,177	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)		5,559,042		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3

Component CCN: 14Z339 | Date/Time Prepared: 2/24/2016 1:42 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.381433	8,590	3,277	50.00
53.00	05300	ANESTHESIOLOGY	0.484419	4,012	1,943	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.126979	149,176	18,942	54.00
60.00	06000	LABORATORY	0.304917	255,200	77,815	60.00
65.00	06500	RESPIRATORY THERAPY	0.361981	153,978	55,737	65.00
66.00	06600	PHYSICAL THERAPY	0.600129	617,420	370,532	66.00
66.01	06601	PHYSICAL THERAPY SNF	0.223142	0	0	66.01
68.00	06800	SPEECH PATHOLOGY	0.475976	45,130	21,481	68.00
69.00	06900	ELECTROCARDIOLOGY	0.178454	6,612	1,180	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.414611	65,488	27,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.379126	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.459414	217,449	99,899	73.00
76.00	03020	OP PSYCH	1.433833	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.883604	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.508859	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,523,055	677,958	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)		1,523,055		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/24/2016 1:42 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,308,590	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)	8,308,590	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)	8,391,676	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)	45,381	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,591,742	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,754,553	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,754,553	30.00
31.00	Primary payer payments	529	31.00
32.00	Subtotal (line 30 minus line 31)	3,754,024	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)	557,949	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	362,667	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	515,597	36.00
37.00	Subtotal (see instructions)	4,116,691	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,116,691	40.00
40.01	Sequestration adjustment (see instructions)	82,334	40.01
41.00	Interim payments	2,247,236	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	1,787,121	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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2016 1:42 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		4,035,826		4,109,070	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	04/21/2015	156,168	3.01
3.02		09/17/2015	100,124		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	04/21/2015	48,558		0	3.50
3.51			0	09/17/2015	2,018,002	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)		51,566		-1,861,834	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)		4,087,392		2,247,236	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		580,500		1,787,121	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,667,892		4,034,357	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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/24/2016 1:42 pm

Component CCN: 14Z339 | 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		2,294,775		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	04/21/2015	9,485		0	3.01
3.02		09/17/2015	1,378,242		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)		1,387,727		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,682,502		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		999,115		0	6.02
7.00	Total Medicare program liability (see instructions)		2,683,387		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: 141339	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/24/2016 1:42 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	1,063	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,650	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,781	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	88,050,709	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,862,783	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: 141339 | Component CCN: 14Z339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-2 | Date/Time Prepared: 2/24/2016 1:42 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)	2,123,968	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)	684,738	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	1,564	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)	2,808,706	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,808,706	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)	2,808,706	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	70,556	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)	2,738,150	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)	2,738,150	0	19.00
19.01	Sequestration adjustment (see instructions)	54,763	0	19.01
20.00	Interim payments	3,682,502	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)	-999,115	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: 141339	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/24/2016 1:42 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,220,341	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)	5,220,341	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,272,544	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)	5,272,544	19.00
20.00	Deductibles (exclude professional component)	591,606	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,680,938	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,680,938	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	126,487	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	82,217	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	121,399	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,763,155	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)	4,763,155	30.00
30.01	Sequestration adjustment (see instructions)	95,263	30.01
31.00	Interim payments	4,087,392	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)	580,500	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141339 Component CCN: 145539	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 2/24/2016 1:42 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/24/2016 1:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	21,094,429	0	0	0	1.00
2.00	Temporary investments	1,566,852	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,483,335	0	0	0	4.00
5.00	Other receivable	491,087	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,632,751	0	0	0	6.00
7.00	Inventory	456,612	0	0	0	7.00
8.00	Prepaid expenses	230,114	0	0	0	8.00
9.00	Other current assets	764,111	0	0	0	9.00
10.00	Due from other funds	24,939	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,478,728	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	743,070	0	0	0	12.00
13.00	Land improvements	3,448,477	0	0	0	13.00
14.00	Accumulated depreciation	-1,456,962	0	0	0	14.00
15.00	Buildings	25,354,455	0	0	0	15.00
16.00	Accumulated depreciation	-9,533,898	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	23,850,219	0	0	0	23.00
24.00	Accumulated depreciation	-19,456,785	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	40,300	0	0	0	27.00
28.00	Accumulated depreciation	-38,982	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)	22,949,894	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,221,629	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	202,485	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,424,114	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	55,852,736	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,066,919	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,172,944	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	54,779	0	0	0	40.00
41.00	Deferred income	484,661	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	22,896	0	0	0	43.00
44.00	Other current liabilities	2,691,728	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,493,927	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	17,951,749	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	390,401	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	18,342,150	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	24,836,077	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,016,659				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)	31,016,659	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	55,852,736	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/24/2016 1:42 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		26,850,396		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,458,542				2.00
3.00	Total (sum of line 1 and line 2)		31,308,938		0		3.00
4.00	TRANSFERS FROM AFFILIATES	-292,487		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)		-292,487		0		10.00
11.00	Subtotal (line 3 plus line 10)		31,016,451		0		11.00
12.00	ROUNDING	-208		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)		-208		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,016,659		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	TRANSFERS FROM AFFILIATES		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	ROUNDING		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: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/24/2016 1:42 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,252,099		5,252,099	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	806,760		806,760	5.00
6.00	Swing bed - NF	245,514		245,514	6.00
7.00	SKILLED NURSING FACILITY	102,952		102,952	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,407,325		6,407,325	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)	6,407,325		6,407,325	17.00
18.00	Ancillary services	11,077,035	67,610,199	78,687,234	18.00
19.00	Outpatient services	118,827	14,133,987	14,252,814	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,603,187	81,744,186	99,347,373	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,465,611		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		37,465,611		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141339 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/24/2016 1:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	99,347,373	1.00
2.00	Less contractual allowances and discounts on patients' accounts	60,975,094	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,372,279	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,465,611	4.00
5.00	Net income from service to patients (line 3 minus line 4)	906,668	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	26,575	6.00
7.00	Income from investments	123,840	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	2,920	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	194,097	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	10,637	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEANINGFUL USE INCOME	0	24.00
24.01	HOSPITAL ACCESS IMPROVEMENT	3,160,640	24.01
24.02	SALE OF REFUSE AND JUNK	1,110	24.02
24.03	MISCELLANEOUS INCOME	18,401	24.03
24.04	GAIN ON DISPOSAL OF ASSETS	95,274	24.04
24.05	GAIN ON DEFERRED COMPENSATION	-81,620	24.05
25.00	Total other income (sum of lines 6-24)	3,551,874	25.00
26.00	Total (line 5 plus line 25)	4,458,542	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,458,542	29.00