

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: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 4/6/2016 3:45 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 4/6/2016	Time: 3:45 pm
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input checked="" type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input checked="" type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 ALEXIAN BROTHERS BEHAVIORAL HEALTH (144031) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	150,251	38,182	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	150,251	38,182	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: 144031		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 4/6/2016 3:43 pm			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1650 MOON LAKE BOULEVARD			PO Box:							1.00	
2.00	City: HOFFMAN ESTATES			State: IL		Zip Code: 60194-		County: COOK			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				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			ALEXIAN BROTHERS BEHAVIORAL HEALTH	144031	16974	4	06/28/1990	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2014		06/30/2015		20.00	
21.00	Type of Control (see instructions)								1		21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								0		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	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 4/6/2016 3:43 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	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		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		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		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	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

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		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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>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.</u>							
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	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: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 4/6/2016 3:43 pm																																																																																																																																																																											
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		1.00	2.00	3.00																																																																																																																																																																											
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		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																																																																																																																																																																									
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(see instructions)</td> <td></td> <td></td> <td></td> <td>N</td> <td>0</td> </tr> <tr> <td colspan="7">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>76.00</td> <td>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)</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Long Term Care Hospital PPS</td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>81.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td>N</td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>87.00</td> <td>Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td></td> <td>N</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td>N</td> <td></td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td></td> <td>N</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> <td></td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? 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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
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 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	608,675	0	0	118.01	
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 4/6/2016 3:43 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	149019	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: ALEXIAN BROTHERS HOSPITAL NETWORK	Contractor's Name: WPS		Contractor's Number: 05001	
142.00	Street: 3040 SALT CREEK LANE	PO Box:		142.00	
143.00	City: ARLINGTON HEIGHTS	State: IL		Zip Code: 60005	
				143.00	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00	
				1.00	
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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
				1.00	
Multi campus					
165.00	Is this hospital part of a Multi campus 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
		0	1.00	2.00	3.00
				CBSA	FTE/Campus
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
				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.	N		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0	
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	
		Beginning		Ending	
		1.00		2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 4/6/2016 3:43 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: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 4/6/2016 3:43 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)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/02/2015	Y	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: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 4/6/2016 3:43 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
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 relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				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	06/30/2015	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.				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.	TONY		LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	LEONE REIMBURSEMENT&CONSULTING			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023		TONY@LEONE-CONSULTING.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	11/02/2015	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.	CPA	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: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
4/6/2016 3:43 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	141	51,465	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		141	51,465	0.00	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)		141	51,465	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						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)		141				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: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
4/6/2016 3:43 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)	15,873	2,387	46,566			1.00
2.00 HMO and other (see instructions)	1,364	766				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	15,873	2,387	46,566			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)	15,873	2,387	46,566	0.00	554.13	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	554.13	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
4/6/2016 3:43 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,239	307	5,908	1.00
2.00 HMO and other (see instructions)				151	79		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		1,239	307	5,908	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 144031		Period: From 07/01/2014 To 06/30/2015		Worksheet S-3 Part II Date/Time Prepared: 4/6/2016 3:43 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	36,939,396	0	36,939,396	0.00	0.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		11,585,577	0	11,585,577	0.00	0.00	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		0	0	0			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	-53,077	0	-53,077	0.00	0.00	26.00
27.00	Administrative & General	5.00	5,161,816	0	5,161,816	0.00	0.00	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	175,160	0	175,160	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	56,131	0	56,131	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	307,360	-64,178	243,182	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	64,178	64,178	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,195,493	0	1,195,493	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part II
Date/Time Prepared:
4/6/2016 3:43 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 448,460	0	448,460	0.00	0.00	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part III
Date/Time Prepared:
4/6/2016 3:43 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	36,939,396	0	36,939,396	0.00	0.00	1.00
2.00	Excluded area salaries (see instructions)	11,585,577	0	11,585,577	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	25,353,819	0	25,353,819	0.00	0.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	0	0	0	0.00	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	25,353,819	0	25,353,819	0.00	0.00	6.00
7.00	Total overhead cost (see instructions)	7,291,343	0	7,291,343	0.00	0.00	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 4/6/2016 3:43 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		0	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		0	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-3
Part V
Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital -Based SNF			8.00
9.00	Hospital -Based NF			9.00
10.00	Hospital -Based OLTC			10.00
11.00	Hospital -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital -Based Hospice			13.00
14.00	Hospital -Based Health Clinic RHC			14.00
15.00	Hospital -Based Health Clinic FQHC			15.00
16.00	Hospital -Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		954,952	954,952	760,552	1,715,504	1.00
2.00	00200		0	0	214,437	214,437	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	-53,077	5,121,964	5,068,887	0	5,068,887	4.00
5.00	00500	5,161,816	19,847,141	25,008,957	-1,709,675	23,299,282	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	175,160	881,564	1,056,724	-95,054	961,670	7.00
8.00	00800	0	0	0	194,136	194,136	8.00
9.00	00900	56,131	955,944	1,012,075	-194,136	817,939	9.00
10.00	01000	307,360	1,944,364	2,251,724	-470,172	1,781,552	10.00
11.00	01100	0	0	0	470,172	470,172	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	1,195,493	127,501	1,322,994	0	1,322,994	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	448,460	401,803	850,263	0	850,263	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	14,253,810	2,589,564	16,843,374	435,640	17,279,014	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	30,797	30,797	177	30,974	54.00
60.00	06000	0	230,907	230,907	47,838	278,745	60.00
66.00	06600	122,002	10,958	132,960	2,761	135,721	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	1,616,827	1,616,827	47,451	1,664,278	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	357,662	106,880	464,542	16,073	480,615	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	3,329,002	440,468	3,769,470	274,331	4,043,801	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		0	0	0	0	113.00
118.00		25,353,819	35,261,634	60,615,453	-5,469	60,609,984	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	1,351,796	632,053	1,983,849	5,186	1,989,035	191.00
192.00	19200	9,620,020	1,410,530	11,030,550	0	11,030,550	192.00
194.00	07950	68,141	7,441	75,582	283	75,865	194.00
194.01	07951	545,620	108,179	653,799	0	653,799	194.01
200.00		36,939,396	37,419,837	74,359,233	0	74,359,233	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A
Date/Time Prepared:
4/6/2016 3:43 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	1,730,329	3,445,833	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	105,069	319,506	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	247,377	5,316,264	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,965,557	20,333,725	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,040,118	2,001,788	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	194,136	8.00
9.00	00900	HOUSEKEEPING	0	817,939	9.00
10.00	01000	DIETARY	0	1,781,552	10.00
11.00	01100	CAFETERIA	-184,340	285,832	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,322,994	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,954	907,217	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	17,279,014	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,974	54.00
60.00	06000	LABORATORY	0	278,745	60.00
66.00	06600	PHYSICAL THERAPY	0	135,721	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,664,278	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	-21,700	458,915	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	PARTIAL HOSPITALIZATION	-116,892	3,926,909	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-108,642	60,501,342	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	RESEARCH	-150,770	1,838,265	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-740,061	10,290,489	192.00
194.00	07950	DUI PROGRAM	0	75,865	194.00
194.01	07951	IPPS	0	653,799	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-999,473	73,359,760	200.00

RECLASSIFICATIONS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6

Date/Time Prepared:
4/6/2016 3:43 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTAL EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	115,014	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS			0	115,014	
B - BUILDING RENTAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	17,119	1.00
2.00		0.00	0	0	2.00
TOTALS			0	17,119	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	64,178	405,994	1.00
TOTALS			64,178	405,994	
D - PFS RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	452,827	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	177	2.00
3.00	LABORATORY	60.00	0	47,838	3.00
4.00	PHYSICAL THERAPY	66.00	0	2,761	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	47,451	5.00
6.00	ELECTROSHOCK THERAPY	76.00	0	18,846	6.00
7.00	PARTIAL HOSPITALIZATION	93.00	0	281,230	7.00
8.00	RESEARCH	191.00	0	5,186	8.00
9.00	DUI PROGRAM	194.00	0	283	9.00
TOTALS			0	856,599	
E - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	194,136	1.00
TOTALS			0	194,136	
F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	842,856	1.00
TOTALS			0	842,856	
H - EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	214,437	1.00
TOTALS			0	214,437	
500.00	Grand Total: Increases		64,178	2,646,155	500.00

RECLASSIFICATIONS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-6
Date/Time Prepared:
4/6/2016 3:43 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENTAL EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	95,054	10	1.00	
2.00	ELECTROSHOCK THERAPY	76.00	0	2,773	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	17,187	0	3.00	
	TOTALS		0	115,014			
B - BUILDING RENTAL							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,220	10	1.00	
2.00	PARTIAL HOSPITALIZATION	93.00	0	6,899	0	2.00	
	TOTALS		0	17,119			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	64,178	405,994	0	1.00	
	TOTALS		64,178	405,994			
D - PFS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	856,599	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
8.00		0.00	0	0	0	8.00	
9.00		0.00	0	0	0	9.00	
	TOTALS		0	856,599			
E - LAUNDRY							
1.00	HOUSEKEEPING	9.00	0	194,136	0	1.00	
	TOTALS		0	194,136			
F - INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	842,856	11	1.00	
	TOTALS		0	842,856			
H - EQUIPMENT DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	214,437	9	1.00	
	TOTALS		0	214,437			
500.00	Grand Total: Decreases		64,178	2,646,155		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part I
Date/Time Prepared:
4/6/2016 3:43 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,540,000	0	0	0	1.00
2.00	Land Improvements	76,152	26,539	0	26,539	2.00
3.00	Buildings and Fixtures	21,305,100	0	0	0	3.00
4.00	Building Improvements	1,288,139	154,577	0	154,577	4.00
5.00	Fixed Equipment	261,875	13,890	0	13,890	5.00
6.00	Movable Equipment	1,912,286	122,586	0	122,586	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,383,552	317,592	0	317,592	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,383,552	317,592	0	317,592	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,540,000	0			1.00
2.00	Land Improvements	102,691	0			2.00
3.00	Buildings and Fixtures	21,305,100	0			3.00
4.00	Building Improvements	1,442,716	0			4.00
5.00	Fixed Equipment	275,765	0			5.00
6.00	Movable Equipment	2,033,579	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	26,699,851	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	26,699,851	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part II
Date/Time Prepared:
4/6/2016 3:43 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	954,952	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	954,952	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	954,952				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	954,952				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-7
Part III
Date/Time Prepared:
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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	24,666,002	0	24,666,002	0.923835	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,033,579	0	2,033,579	0.076165	0	2.00
3.00	Total (sum of lines 1-2)	26,699,581	0	26,699,581	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,443,557	132,133	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	319,506	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,763,063	132,133	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	870,143	0	0	0	3,445,833	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	319,506	2.00
3.00	Total (sum of lines 1-2)	870,143	0	0	0	3,765,339	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			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		0				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	1,356,670					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-184,340	CAFETERIA		11.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-1,256	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	*** Cost Center Deleted ***	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	A	-17,848	CAP REL COSTS-BLDG & FIXT		1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	105,069	CAP REL COSTS-MVBLE EQUIP		2.00		9	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		0	28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 MISC INCOME	B	-825	ADMINISTRATIVE & GENERAL		5.00		0	33.00
33.01 MISC INCOME	B	-63,353	PARTIAL HOSPITALIZATION		93.00		0	33.01

Provider CCN: 144031
 Period: From 07/01/2014 To 06/30/2015
 Worksheet A-8
 Date/Time Prepared: 4/6/2016 3:43 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.02 RESEARCH HBP	A	-150,770	RESEARCH	191.00	0 33.02
33.03 GROUP PRACTICE HBP	A	-979,497	PHYSICIANS' PRIVATE OFFICES	192.00	0 33.03
33.05 PHYSICIAN GUARANTEE	A	-10,621	ADMINISTRATIVE & GENERAL	5.00	0 33.05
34.00 BUSINESS DEVELOPMENT/MARKETING	A	-323,355	ADMINISTRATIVE & GENERAL	5.00	0 34.00
35.00 BUSINESS DEVELOPMENT OTHER INCO	B	-71,270	ADMINISTRATIVE & GENERAL	5.00	0 35.00
36.00 ECT OTHER INCOME	B	-21,700	ELECTROSHOCK THERAPY	76.00	0 36.00
37.00 SCHOOL REIMBURSEMENT	A	-521,601	ADMINISTRATIVE & GENERAL	5.00	0 37.00
38.00 OTHER INCOME - AFTERCARE	B	-53,539	PARTIAL HOSPITALIZATION	93.00	0 38.00
39.00 REAL ESTATE TAXES	A	-6,700	ADMINISTRATIVE & GENERAL	5.00	0 39.00
40.01 OTHER PRO FEES	B	-53,337	ADMINISTRATIVE & GENERAL	5.00	0 40.01
40.03 DONATIONS	A	-1,200	ADMINISTRATIVE & GENERAL	5.00	0 40.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-999,473			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: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-1

Date/Time Prepared:
4/6/2016 3:43 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ABHN NON CAP	7,695,955	10,664,542
2.00	0.00			0	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	27,287	0
3.01	16.00	MEDICAL RECORDS & LIBRARY	ICD 10 TRAINING	58,210	0
3.02	1.00	CAP REL COSTS-BLDG & FIXT	ABHN CAPITAL	1,720,890	0
3.03	0.00			0	0
3.04	7.00	OPERATION OF PLANT	CLINICAL ENGINEERING	1,040,118	0
3.05	5.00	ADMINISTRATIVE & GENERAL	EXECUTIVE SALARIES	992,088	149
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	EXECUTIVE BENEFITS	247,386	9
3.07	0.00			0	0
3.08	0.00			0	0
3.09	0.00			0	0
3.10	0.00			0	0
3.11	192.00	PHYSICIANS' PRIVATE OFFICES	ABMP NON CAPITAL	239,436	0
3.12	0.00			0	0
4.00	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,021,370	10,664,700

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

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

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

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

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

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

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

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

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-1

Date/Time Prepared:
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	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	-2,968,587	0		1.00
2.00	0	0		2.00
3.00	27,287	11		3.00
3.01	58,210	0		3.01
3.02	1,720,890	9		3.02
3.03	0	9		3.03
3.04	1,040,118	0		3.04
3.05	991,939	0		3.05
3.06	247,377	0		3.06
3.07	0	9		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	239,436	0		3.11
3.12	0	0		3.12
4.00	0	0		4.00
5.00	1,356,670			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			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	DR. A	190,663	0	190,663	200,000	2,080	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			190,663	0	190,663		2,080	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	DR. A	200,000	10,000	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			200,000	10,000	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	DR. A	0	200,000	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	200,000	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,445,833	3,445,833			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	319,506		319,506		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,316,264	0	0	5,316,264	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,333,725	1,061,664	98,440	741,815	22,235,644
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	2,001,788	16,164	1,499	25,173	2,044,624
8.00 00800	LAUNDRY & LINEN SERVICE	194,136	7,175	665	0	201,976
9.00 00900	HOUSEKEEPING	817,939	4,034	374	8,067	830,414
10.00 01000	DIETARY	1,781,552	45,269	4,197	34,948	1,865,966
11.00 01100	CAFETERIA	285,832	73,184	6,786	9,223	375,025
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	1,322,994	0	0	171,807	1,494,801
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	907,217	28,862	2,676	64,449	1,003,204
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,279,014	1,616,377	149,876	2,048,445	21,093,712
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	30,974	0	0	0	30,974
60.00 06000	LABORATORY	278,745	0	0	0	278,745
66.00 06600	PHYSICAL THERAPY	135,721	0	0	17,533	153,254
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,664,278	12,319	1,142	0	1,677,739
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03320	ELECTROSHOCK THERAPY	458,915	16,678	1,546	51,400	528,539
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
93.00 04950	PARTIAL HOSPITALIZATION	3,926,909	150,212	13,928	478,418	4,569,467
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	60,501,342	3,031,938	281,129	3,651,278	58,384,084
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	1,838,265	5,577	517	194,269	2,038,628
192.00 19200	PHYSICIANS' PRIVATE OFFICES	10,290,489	408,318	37,860	1,382,512	12,119,179
194.00 07950	DUI PROGRAM	75,865	0	0	9,793	85,658
194.01 07951	IPPS	653,799	0	0	78,412	732,211
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	73,359,760	3,445,833	319,506	5,316,264	73,359,760

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet B
Part I
Date/Time Prepared:
4/6/2016 3:43 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	22,235,644				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	889,279	0	2,933,903		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,846	0	8,889	298,711	8.00
9.00	00900	HOUSEKEEPING	361,176	0	4,998	0	1,196,588
10.00	01000	DIETARY	811,574	0	56,088	0	22,984
11.00	01100	CAFETERIA	163,111	0	90,673	0	37,157
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	650,141	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	436,329	0	35,759	0	14,654
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,174,370	0	2,002,654	298,711	820,663
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,472	0	0	0	0
60.00	06000	LABORATORY	121,236	0	0	0	0
66.00	06600	PHYSICAL THERAPY	66,656	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	729,707	0	15,263	0	6,255
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03320	ELECTROSHOCK THERAPY	229,880	0	20,664	0	8,468
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04950	PARTIAL HOSPITALIZATION	1,987,421	0	186,109	0	76,265
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,722,198	0	2,421,097	298,711	986,446
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	886,671	0	6,910	0	2,832
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,271,055	0	505,896	0	207,310
194.00	07950	DUI PROGRAM	37,256	0	0	0	0
194.01	07951	IPPS	318,464	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	22,235,644	0	2,933,903	298,711	1,196,588

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	2,756,612					10.00
11.00	01100		665,966				11.00
12.00	01200			0			12.00
13.00	01300		23,602		2,168,544		13.00
14.00	01400					0	14.00
15.00	01500						15.00
16.00	01600		13,066				16.00
17.00	01700						17.00
19.00	01900						19.00
20.00	02000						20.00
21.00	02100						21.00
22.00	02200						22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,756,612	363,812	0	1,675,447	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
66.00	06600	0	2,312	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	0	7,617	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	0	94,797	0	493,097	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,756,612	505,206	0	2,168,544	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	18,789	0	0	0	191.00
192.00	19200	0	124,498	0	0	0	192.00
194.00	07950	0	1,445	0	0	0	194.00
194.01	07951	0	16,028	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,756,612	665,966	0	2,168,544	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	0					15.00
16.00	01600	0	1,503,012				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0		0	20.00
21.00	02100	0	0	0			21.00
22.00	02200	0	0	0			22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	799,676	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	313	0	0	0	54.00
60.00	06000	0	84,474	0	0	0	60.00
66.00	06600	0	4,875	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	83,791	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	0	33,279	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	0	496,604	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		0	1,503,012	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		0	1,503,012	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
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
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	0	38,985,657	38,985,657
ANCILLARY SERVICE COST CENTERS					
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	44,759	44,759
60.00 06000	LABORATORY	0	0	484,455	484,455
66.00 06600	PHYSICAL THERAPY	0	0	227,097	227,097
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	2,512,755	2,512,755
74.00 07400	RENAL DIALYSIS	0	0	0	0
76.00 03320	ELECTROSHOCK THERAPY	0	0	828,447	828,447
76.97 07697	CARDIAC REHABILITATION	0	0	0	0
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0
76.99 07699	LITHOTRI PSY	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0	0
93.00 04950	PARTIAL HOSPITALIZATION	0	0	7,903,760	7,903,760
OTHER REIMBURSABLE COST CENTERS					
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	50,986,930	50,986,930
NONREIMBURSABLE COST CENTERS					
191.00 19100	RESEARCH	0	0	2,953,830	2,953,830
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	18,227,938	18,227,938
194.00 07950	DUI PROGRAM	0	0	124,359	124,359
194.01 07951	I PPS	0	0	1,066,703	1,066,703
200.00	Cross Foot Adjustments	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	0	73,359,760	73,359,760

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144031

Period:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,061,664	98,440	1,160,104	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	16,164	1,499	17,663	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,175	665	7,840	8.00
9.00 00900	HOUSEKEEPING	0	4,034	374	4,408	9.00
10.00 01000	DIETARY	0	45,269	4,197	49,466	10.00
11.00 01100	CAFETERIA	0	73,184	6,786	79,970	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	28,862	2,676	31,538	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,616,377	149,876	1,766,253	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	12,319	1,142	13,461	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0	16,678	1,546	18,224	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	150,212	13,928	164,140	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,031,938	281,129	3,313,067	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	0	5,577	517	6,094	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	408,318	37,860	446,178	192.00
194.00 07950	DUI PROGRAM	0	0	0	0	194.00
194.01 07951	IPPS	0	0	0	0	194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	3,445,833	319,506	3,765,339	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 4/6/2016 3:43 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	1,160,104				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	46,397	0	64,060		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,583	0	194	12,617	8.00
9.00	00900	HOUSEKEEPING	18,844	0	109	0	23,361
10.00	01000	DIETARY	42,343	0	1,225	0	449
11.00	01100	CAFETERIA	8,510	0	1,980	0	725
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	33,920	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	22,765	0	781	0	286
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	478,653	0	43,726	12,617	16,023
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	703	0	0	0	0
60.00	06000	LABORATORY	6,325	0	0	0	0
66.00	06600	PHYSICAL THERAPY	3,478	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	38,071	0	333	0	122
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03320	ELECTROSHOCK THERAPY	11,994	0	451	0	165
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRI PSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04950	PARTIAL HOSPITALIZATION	103,690	0	4,064	0	1,489
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	820,276	0	52,863	12,617	19,259
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	46,261	0	151	0	55
192.00	19200	PHYSICIANS' PRIVATE OFFICES	275,008	0	11,046	0	4,047
194.00	07950	DUI PROGRAM	1,944	0	0	0	0
194.01	07951	IPPS	16,615	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,160,104	0	64,060	12,617	23,361

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 144031		Period: From 07/01/2014 To 06/30/2015		Worksheet B Part II Date/Time Prepared: 4/6/2016 3:43 pm	
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	93,483					10.00
11.00	01100	0	91,185				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	3,232	0	37,152		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	1,789	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	93,483	49,812	0	28,704	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
66.00	06600	0	317	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	0	1,043	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	0	12,980	0	8,448	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		93,483	69,173	0	37,152	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	2,573	0	0	0	191.00
192.00	19200	0	17,046	0	0	0	192.00
194.00	07950	0	198	0	0	0	194.00
194.01	07951	0	2,195	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		93,483	91,185	0	37,152	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 4/6/2016 3:43 pm		
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL
		15.00	16.00	17.00	19.00	20.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	0			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,159		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	30,423	0	30.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12	0	54.00
60.00	06000	LABORATORY	0	3,211	0	60.00
66.00	06600	PHYSICAL THERAPY	0	185	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,185	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	1,265	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	18,878	0	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	57,159	0	118.00
NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	DUI PROGRAM	0	0	0	194.00
194.01	07951	IPPS	0	0	0	194.01
200.00		Cross Foot Adjustments			0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	57,159	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet B Part II Date/Time Prepared: 4/6/2016 3:43 pm
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Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
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
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS		2,519,694	0	2,519,694
ANCILLARY SERVICE COST CENTERS					
54.00 05400	RADIOLOGY-DIAGNOSTIC		715	0	715
60.00 06000	LABORATORY		9,536	0	9,536
66.00 06600	PHYSICAL THERAPY		3,980	0	3,980
69.00 06900	ELECTROCARDIOLOGY		0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS		55,172	0	55,172
74.00 07400	RENAL DIALYSIS		0	0	0
76.00 03320	ELECTROSHOCK THERAPY		33,142	0	33,142
76.97 07697	CARDIAC REHABILITATION		0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY		0	0	0
76.99 07699	LITHOTRIPSY		0	0	0
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0	
93.00 04950	PARTIAL HOSPITALIZATION		313,689	0	313,689
OTHER REIMBURSABLE COST CENTERS					
94.00 09400	HOME PROGRAM DIALYSIS		0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,935,928	0	2,935,928
NONREIMBURSABLE COST CENTERS					
191.00 19100	RESEARCH		55,134	0	55,134
192.00 19200	PHYSICIANS' PRIVATE OFFICES		753,325	0	753,325
194.00 07950	DUI PROGRAM		2,142	0	2,142
194.01 07951	IPPS		18,810	0	18,810
200.00	Cross Foot Adjustments	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	3,765,339	0	3,765,339

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	127,270				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		127,270			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	36,992,473		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	39,212	39,212	5,161,816	-22,235,644	51,124,116
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	597	597	175,160	0	2,044,624
8.00 00800	LAUNDRY & LINEN SERVICE	265	265	0	0	201,976
9.00 00900	HOUSEKEEPING	149	149	56,131	0	830,414
10.00 01000	DIETARY	1,672	1,672	243,182	0	1,865,966
11.00 01100	CAFETERIA	2,703	2,703	64,178	0	375,025
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	1,195,493	0	1,494,801
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	448,460	0	1,003,204
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	59,700	59,700	14,253,810	0	21,093,712
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	30,974
60.00 06000	LABORATORY	0	0	0	0	278,745
66.00 06600	PHYSICAL THERAPY	0	0	122,002	0	153,254
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	455	455	0	0	1,677,739
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03320	ELECTROSHOCK THERAPY	616	616	357,662	0	528,539
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00 04950	PARTIAL HOSPITALIZATION	5,548	5,548	3,329,002	0	4,569,467
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	111,983	111,983	25,406,896	-22,235,644	36,148,440
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	206	206	1,351,796	0	2,038,628
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,081	15,081	9,620,020	0	12,119,179
194.00 07950	DUI PROGRAM	0	0	68,141	0	85,658
194.01 07951	IPPS	0	0	545,620	0	732,211
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	3,445,833	319,506	5,316,264		22,235,644
203.00	Unit cost multiplier (Wkst. B, Part I)	27.074982	2.510458	0.143712		0.434935
204.00	Cost to be allocated (per Wkst. B, Part II)			0		1,160,104
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.022692

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	0					6.00
7.00	00700		87,461				7.00
8.00	00800		265	100			8.00
9.00	00900		149		87,047		9.00
10.00	01000		1,672		1,672	142,158	10.00
11.00	01100		2,703		2,703		11.00
12.00	01200		0		0		12.00
13.00	01300		0		0		13.00
14.00	01400		0		0		14.00
15.00	01500		0		0		15.00
16.00	01600		1,066		1,066		16.00
17.00	01700		0		0		17.00
19.00	01900		0		0		19.00
20.00	02000		0		0		20.00
21.00	02100		0		0		21.00
22.00	02200		0		0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000		59,700	100	59,700	142,158	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400		0	0	0	0	54.00
60.00	06000		0	0	0	0	60.00
66.00	06600		0	0	0	0	66.00
69.00	06900		0	0	0	0	69.00
73.00	07300		455		455		73.00
74.00	07400		0		0		74.00
76.00	03320		616		616		76.00
76.97	07697		0		0		76.97
76.98	07698		0		0		76.98
76.99	07699		0		0		76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950		5,548		5,548		93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400		0		0		94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00			72,174	100	71,760	142,158	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100		206		206		191.00
192.00	19200		15,081		15,081		192.00
194.00	07950		0		0		194.00
194.01	07951		0		0		194.01
200.00							200.00
201.00							201.00
202.00			2,933,903	298,711	1,196,588	2,756,612	202.00
203.00		0.000000	33,545,272	2,987,110,000	13,746,459	19,391,184	203.00
204.00			64,060	12,617	23,361	93,483	204.00
205.00		0.000000	0.732441	126.170000	0.268372	0.657599	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (FULL TIME EQUIV'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	46,078					11.00
12.00	01200	0	0				12.00
13.00	01300	1,633	0	579,921			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	904	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	25,172	0	448,055	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
66.00	06600	160	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	527	0	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	6,559	0	131,866	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		34,955	0	579,921	0	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	1,300	0	0	0	0	191.00
192.00	19200	8,614	0	0	0	0	192.00
194.00	07950	100	0	0	0	0	194.00
194.01	07951	1,109	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		665,966	0	2,168,544	0	0	202.00
203.00		14.453014	0.000000	3.739378	0.000000	0.000000	203.00
204.00		91,185	0	37,152	0	0	204.00
205.00		1.978927	0.000000	0.064064	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	21.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
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	148,015,197				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	78,748,330	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,861	0	0	0	54.00
60.00	06000	LABORATORY	8,319,277	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	480,100	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,252,021	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	3,277,390	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	PARTIAL HOSPITALIZATION	48,907,218	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	148,015,197	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	DUI PROGRAM	0	0	0	0	194.00
194.01	07951	IPPS	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,503,012	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010154	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57,159	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000386	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet B-1

Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description		INTERNS & RESIDENTS	
		SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
		22.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03320	ELECTROSHOCK THERAPY	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04950	PARTIAL HOSPITALIZATION	93.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	DUI PROGRAM	194.00
194.01	07951	IPPS	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	38,985,657		38,985,657	0	38,985,657	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	44,759		44,759	0	44,759	54.00
60.00	06000 LABORATORY	484,455		484,455	0	484,455	60.00
66.00	06600 PHYSICAL THERAPY	227,097	0	227,097	0	227,097	66.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,512,755		2,512,755	0	2,512,755	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	828,447		828,447	0	828,447	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	7,903,760		7,903,760	0	7,903,760	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	50,986,930	0	50,986,930	0	50,986,930	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	50,986,930	0	50,986,930	0	50,986,930	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				
		9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	78,748,330		78,748,330			30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,861	0	30,861	1.450342	0.000000	54.00
60.00	06000	LABORATORY	8,272,744	46,533	8,319,277	0.058233	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	480,100	0	480,100	0.473020	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,282,951	969,070	8,252,021	0.304502	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03320	ELECTROSHOCK THERAPY	1,645,170	1,632,220	3,277,390	0.252776	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	48,907,218	48,907,218	0.161607	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	96,460,156	51,555,041	148,015,197			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	96,460,156	51,555,041	148,015,197			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 4/6/2016 3:43 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS			
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.450342		54.00
60.00	06000 LABORATORY	0.058233		60.00
66.00	06600 PHYSICAL THERAPY	0.473020		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304502		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03320 ELECTROSHOCK THERAPY	0.252776		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.161607		93.00
	OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	38,985,657		38,985,657	0	38,985,657	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	44,759		44,759	0	44,759	54.00
60.00	06000 LABORATORY	484,455		484,455	0	484,455	60.00
66.00	06600 PHYSICAL THERAPY	227,097	0	227,097	0	227,097	66.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,512,755		2,512,755	0	2,512,755	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	828,447		828,447	0	828,447	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	7,903,760		7,903,760	0	7,903,760	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	50,986,930	0	50,986,930	0	50,986,930	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	50,986,930	0	50,986,930	0	50,986,930	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet C
Part I
Date/Time Prepared:
4/6/2016 3:43 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	78,748,330		78,748,330		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,861	0	30,861	1.450342	54.00
60.00	06000	LABORATORY	8,272,744	46,533	8,319,277	0.058233	60.00
66.00	06600	PHYSICAL THERAPY	480,100	0	480,100	0.473020	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,282,951	969,070	8,252,021	0.304502	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03320	ELECTROSHOCK THERAPY	1,645,170	1,632,220	3,277,390	0.252776	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	48,907,218	48,907,218	0.161607	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	96,460,156	51,555,041	148,015,197		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	96,460,156	51,555,041	148,015,197		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 4/6/2016 3:43 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03320 ELECTROSHOCK THERAPY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 144031		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part I Date/Time Prepared: 4/6/2016 3:43 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,519,694	0	2,519,694	46,566	54.11	30.00
200.00	Total (Lines 30-199)	2,519,694		2,519,694	46,566		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	15,873	858,888				
200.00	Total (Lines 30-199)	15,873	858,888				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 4/6/2016 3:43 pm
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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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	715	30,861	0.023168	16,681	386	54.00
60.00	06000	LABORATORY	9,536	8,319,277	0.001146	2,550,808	2,923	60.00
66.00	06600	PHYSICAL THERAPY	3,980	480,100	0.008290	413,407	3,427	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,172	8,252,021	0.006686	3,408,558	22,790	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	33,142	3,277,390	0.010112	948,070	9,587	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	313,689	48,907,218	0.006414	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	416,234	69,266,867		7,337,524	39,113	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144031		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part III Date/Time Prepared: 4/6/2016 3:43 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,566	0.00	15,873	0		30.00
200.00		Total (lines 30-199)	46,566		15,873	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
76.00	03320	ELECTROSHOCK THERAPY	0	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
93.00	04950	PARTIAL HOSPITALIZATION	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00	
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: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
4/6/2016 3:43 pm

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)	Hospital			
					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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,861	0.000000	0.000000	16,681	54.00
60.00	06000	LABORATORY	0	8,319,277	0.000000	0.000000	2,550,808	60.00
66.00	06600	PHYSICAL THERAPY	0	480,100	0.000000	0.000000	413,407	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,252,021	0.000000	0.000000	3,408,558	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	3,277,390	0.000000	0.000000	948,070	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	48,907,218	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	0	69,266,867			7,337,524	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet D
Part IV
Date/Time Prepared:
4/6/2016 3:43 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	19,441	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	339,100	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	819,160	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	1,843,434	0	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00		Total (lines 50-199)	0	3,021,135	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 4/6/2016 3:43 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	1.450342	0	0	0	54.00
60.00 06000	LABORATORY	0.058233	19,441	0	1,132	60.00
66.00 06600	PHYSICAL THERAPY	0.473020	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.304502	339,100	0	103,257	73.00
74.00 07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0.252776	819,160	0	207,064	76.00
76.97 07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99 07699	LITHOTRIpsy	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
93.00 04950	PARTIAL HOSPITALIZATION	0.161607	1,843,434	0	297,912	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0.000000		0		94.00
200.00	Subtotal (see instructions)		3,021,135	0	609,365	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		3,021,135	0	609,365	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 144031		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part V Date/Time Prepared: 4/6/2016 3:43 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description		Costs					
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	06000	LABORATORY	0	0			60.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400	RENAL DIALYSIS	0	0			74.00
76.00	03320	ELECTROSHOCK THERAPY	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0			76.98
76.99	07699	LITHOTRIpsy	0	0			76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	0			93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0			94.00
200.00		Subtotal (see instructions)	0	0			200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0				201.00
202.00		Net Charges (line 200 +/- line 201)	0	0			202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 4/6/2016 3:43 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		46,566	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		46,566	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)		46,566	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)		15,873	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		38,985,657	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)		38,985,657	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)		38,985,657	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)		837.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,289,034	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)		13,289,034	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 4/6/2016 3:43 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
	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)				1,645,846	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				14,934,880	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)				858,888	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				39,113	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				898,001	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				14,036,879	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				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: 144031		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 4/6/2016 3:43 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,519,694	38,985,657	0.064631	0	0	90.00
91.00	Nursing School cost	0	38,985,657	0.000000	0	0	91.00
92.00	Allied health cost	0	38,985,657	0.000000	0	0	92.00
93.00	All other Medical Education	0	38,985,657	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 4/6/2016 3:43 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		46,566	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		46,566	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)		46,566	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)		2,387	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		38,985,657	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)		38,985,657	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)		38,985,657	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)		837.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,998,420	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)		1,998,420	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 4/6/2016 3:43 pm	
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)
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00
42.00	Intensive Care Type Inpatient Hospital Units					42.00
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,998,420 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/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)					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: 144031		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 4/6/2016 3:43 pm	
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	2,519,694	38,985,657	0.064631	0	0	90.00
91.00	Nursing School cost	0	38,985,657	0.000000	0	0	91.00
92.00	Allied health cost	0	38,985,657	0.000000	0	0	92.00
93.00	All other Medical Education	0	38,985,657	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 4/6/2016 3:43 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		27,100,550		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.450342	16,681	24,193	54.00
60.00	06000 LABORATORY	0.058233	2,550,808	148,541	60.00
66.00	06600 PHYSICAL THERAPY	0.473020	413,407	195,550	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304502	3,408,558	1,037,913	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	0.252776	948,070	239,649	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.161607	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50-94 and 96-98)		7,337,524	1,645,846	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		7,337,524		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 4/6/2016 3:43 pm	
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					
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.450342		0	54.00
60.00	06000 LABORATORY	0.058233		0	60.00
66.00	06600 PHYSICAL THERAPY	0.473020		0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304502		0	73.00
74.00	07400 RENAL DIALYSIS	0.000000		0	74.00
76.00	03320 ELECTROSHOCK THERAPY	0.252776		0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		0	76.98
76.99	07699 LI THOTRI PSY	0.000000		0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.161607		0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		0	94.00
200.00	Total (sum of lines 50-94 and 96-98)			0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0	201.00
202.00	Net Charges (line 200 minus line 201)			0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 4/6/2016 3:43 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		609,365	2.00
3.00	PPS payments		763,963	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)		0	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 charge basis 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)		0	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)		763,963	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		153,594	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)		610,369	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)		610,369	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		610,369	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)		59,935	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		38,958	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		18,161	36.00
37.00	Subtotal (see instructions)		649,327	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)		649,327	40.00
40.01	Sequestration adjustment (see instructions)		12,987	40.01
41.00	Interim payments		598,158	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		38,182	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: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
4/6/2016 3:43 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		12,477,778		598,158	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		188,119		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	01/28/2015	64,800		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		64,800		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		12,730,697		598,158	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		150,251		38,182	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		12,880,948		636,340	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		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part II Date/Time Prepared: 4/6/2016 3:43 pm
		Title XVIII	Hospital	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			13,604,995 1.00
2.00	Net IPF PPS Outlier Payments			39,272 2.00
3.00	Net IPF PPS ECT Payments			256,177 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			127.578082 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			13,900,444 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			13,900,444 16.00
17.00	Primary payer payments			4,570 17.00
18.00	Subtotal (line 16 less line 17).			13,895,874 18.00
19.00	Deductibles			877,924 19.00
20.00	Subtotal (line 18 minus line 19)			13,017,950 20.00
21.00	Coinsurance			285,453 21.00
22.00	Subtotal (line 20 minus line 21)			12,732,497 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			632,812 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			411,328 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			90,712 25.00
26.00	Subtotal (sum of lines 22 and 24)			13,143,825 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			13,143,825 31.00
31.01	Sequestration adjustment (see instructions)			262,877 31.01
32.00	Interim payments			12,730,697 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			150,251 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			39,272 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144031	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 4/6/2016 3:43 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,998,420		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,998,420	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,998,420	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		1,998,420	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		1,998,420	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet G

Date/Time Prepared:
4/6/2016 3:43 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	147,089	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,318,247	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	115,007	0	0	0	7.00
8.00	Prepaid expenses	8,617	0	0	0	8.00
9.00	Other current assets	143,785	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,732,745	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,540,000	0	0	0	12.00
13.00	Land improvements	102,691	0	0	0	13.00
14.00	Accumulated depreciation	-19,948	0	0	0	14.00
15.00	Buildings	21,305,100	0	0	0	15.00
16.00	Accumulated depreciation	-2,073,546	0	0	0	16.00
17.00	Leasehold improvements	1,442,716	0	0	0	17.00
18.00	Accumulated depreciation	-256,670	0	0	0	18.00
19.00	Fixed equipment	275,765	0	0	0	19.00
20.00	Accumulated depreciation	-65,359	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	2,036,166	0	0	0	23.00
24.00	Accumulated depreciation	-894,183	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,392,732	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	146,855	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	146,855	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,272,332	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	11,381,712	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,381,712	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,613,757	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,613,757	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,995,469	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	20,276,863				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)	20,276,863	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,272,332	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-1

Date/Time Prepared:
4/6/2016 3:43 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		26,436,223		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,342,361			2.00
3.00	Total (sum of line 1 and line 2)		31,778,584		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		31,778,584		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	TRANSFERS TO AFFILIATES	11,501,721		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		11,501,721		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,276,863		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	TRANSFERS TO AFFILIATES		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: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
4/6/2016 3:43 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	78,748,330		78,748,330	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	78,748,330		78,748,330	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)	78,748,330		78,748,330	17.00
18.00	Ancillary services	17,711,826	2,647,283	20,359,109	18.00
19.00	Outpatient services	0	48,907,218	48,907,218	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	RESEARCH	901,890	0	901,890	27.00
27.01	PHYSICIAN PRIVATE OFFICE	0	18,537,198	18,537,198	27.01
27.02	OTHER NRCC	0	49,259	49,259	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	97,362,046	70,140,958	167,503,004	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		74,359,233		29.00
30.00		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)		74,359,233		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144031

Period:
From 07/01/2014
To 06/30/2015

Worksheet G-3

Date/Time Prepared:
4/6/2016 3:43 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	167,503,004	1.00
2.00	Less contractual allowances and discounts on patients' accounts	94,111,606	2.00
3.00	Net patient revenues (line 1 minus line 2)	73,391,398	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	74,359,233	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-967,835	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	986	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	184,340	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,256	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	CAPITATION REVENUE	656,764	24.00
24.01	SCHOOL EDUCATION REIMBURSEMENT	1,294,640	24.01
24.02	BUSINESS DEVELOPMENT	84,952	24.02
24.03	RESTRICTED FUNDS	297,932	24.03
24.04	CLINICAL RESEARCH	1,940,391	24.04
24.05	MISC REVENUE	99,343	24.05
24.06	IPPS REVENUE	634,640	24.06
24.07	ABMP PROFESSIONAL FEES	53,337	24.07
24.08	INTERNS AND RESIDENTS	564,448	24.08
24.09	INTAKE	53,599	24.09
24.10	ECT PUBLIC AID	21,700	24.10
24.11	PATIENT ACCOUNTS	25,955	24.11
24.12	SAFE PROGRAM	12,475	24.12
24.13	EDUCATION	659	24.13
24.14	OTHER FEES	70,692	24.14
24.15	COMMUNITY ACTIVITY	16,293	24.15
24.16	ABPS REV	295,794	24.16
24.17	GAIN ON SALE M/E	0	24.17
25.00	Total other income (sum of lines 6-24)	6,310,196	25.00
26.00	Total (line 5 plus line 25)	5,342,361	26.00
27.00	RECONCILING AMOUNT	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,342,361	29.00