

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

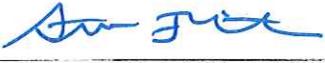
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 144034	Period: From 07/01/2014 To 06/30/2015	Worksheet 5 Parts I-III Date/Time Prepared: 11/5/2015 9:14 am
--	----------------------	---	--

PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input 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.	Date:	Time:
Contractor use only	5. <input 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 STREAMWOOD (144034) 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: SVP & CFO
 Date: 11/6/15

Cost Center Description	Title V		Title XVIII		HIT	Title XIX	
	1.00	2.00	Part A	Part B			
PART III - SETTLEMENT SUMMARY							
1.00 Hospital	0	0	0	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	0	6.00
200.00 Total	0	0	0	0	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: 144034

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

Worksheet S-2
Part I
Date/Time Prepared:
10/23/2015 10:44 am

		1.00	2.00	3.00	4.00						
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1400 EAST IRVING PARK	PO Box:		Zip Code: 60107		County: COOK			1.00		
2.00	City: STREAMWOOD	State: IL							2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	STREAMWOOD		144034	16974	4	05/01/1991	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)						4		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144034	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 10/23/2015 10:44 am			
		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 in effect in the cost reporting period.	0			37.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00		
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete wkst. L, Pt. III and wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete wkst. D-5.				58.00		
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 144034

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

Worksheet S-2
Part I
Date/Time Prepared:
10/23/2015 10:44 am

		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		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	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	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				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, §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.	N			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.	0			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144034	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 10/23/2015 10:44 am				
			1.00	2.00				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00			
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00			
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00			
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	399001	140.00			
		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: UNIVERSAL HEALTH SERVICES	Contractor's Name: 399001	Contractor's Number: 399001		141.00			
142.00	Street: 367 SOUTH GULPH ROAD	PO Box:			142.00			
143.00	City: KING OF PRUSSIA	State: PA	Zip Code:	19406	143.00			
				1.00				
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00			
145.00	If costs for renal services are claimed on worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00			
			1.00	2.00				
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00			
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00			
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00			
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	157.00		
158.00	SUBPROVIDER					158.00		
159.00	SNF	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00		
161.00	CMHC		N	N	N	161.00		
					1.00			
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00		
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				N		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144034	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 10/23/2015 10:44 am
			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
			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)			171.00
			N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144034	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 10/23/2015 10:44 am
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Y/N		
		1.00		
PS&R Data				
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/26/2012	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
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
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
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

	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2011
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	UHS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-312-5742		KEVIN.SMITH@UHSINC.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/26/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

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

Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P	
	Line Number		Available		Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	162	59,130	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)		162	59,130	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)		162	59,130	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	46.00	0	0			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)		162				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: 144034

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

Worksheet S-3
Part I
Date/Time Prepared:
10/23/2015 10:44 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	0	23,453	37,545			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	23,453	37,545			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	23,453	37,545	0.00	257.30	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			0	0.00	0.00	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	257.30	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

Component	Full Time 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	0	1,576	2,846	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	0		1,576	2,846	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	0.00					0	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

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.327937	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			0	6.00
7.00	Medicaid cost (line 1 times line 6)			0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			0	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			0	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			0	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			0	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			0	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144034

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

Worksheet A

Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		2,352,972	2,352,972	12,659	2,365,631	1.00
2.00	00200		301,922	301,922	124,843	426,765	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	343,141	3,089,284	3,432,425	0	3,432,425	4.00
5.00	00500	2,280,139	3,809,551	6,089,690	-620,112	5,469,578	5.00
7.00	00700	370	1,199,358	1,199,728	-5,411	1,194,317	7.00
8.00	00800	0	211,747	211,747	0	211,747	8.00
9.00	00900	0	580,540	580,540	0	580,540	9.00
10.00	01000	262,700	386,422	649,122	0	649,122	10.00
13.00	01300	893,377	3,313	896,690	0	896,690	13.00
16.00	01600	225,213	134,563	359,776	0	359,776	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,065,777	2,715,084	9,780,861	0	9,780,861	30.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	80,235	80,235	0	80,235	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	563,306	563,306	0	563,306	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,378,122	644,492	2,022,614	126,713	2,149,327	90.00
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
118.00		12,448,839	16,072,789	28,521,628	-361,308	28,160,320	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	1,613,511	55,090	1,668,601	0	1,668,601	194.01
194.02	07952	0	0	0	361,308	361,308	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		14,062,350	16,127,879	30,190,229	0	30,190,229	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144034

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

Worksheet A

Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	26,181	2,391,812	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-49,152	377,613	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	199,313	3,631,738	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,912,909	3,556,669	5.00
7.00	00700	OPERATION OF PLANT	0	1,194,317	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	211,747	8.00
9.00	00900	HOUSEKEEPING	0	580,540	9.00
10.00	01000	DIETARY	-4,339	644,783	10.00
13.00	01300	NURSING ADMINISTRATION	0	896,690	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	359,776	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,308,728	7,472,133	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	80,235	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	563,306	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-589,191	1,560,136	90.00
91.00	09100	EMERGENCY	0	0	91.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,638,825	23,521,495	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	EDUCATION	0	1,668,601	194.01
194.02	07952	MARKETING	0	361,308	194.02
194.03	07953	PHP MEALS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-4,638,825	25,551,404	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 144034

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

Worksheet Non-CMS W

Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
46.00	OTHER LONG TERM CARE	04600		46.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	07950		194.00
194.01	EDUCATION	07951		194.01
194.02	MARKETING	07952		194.02
194.03	PHP MEALS	07953		194.03
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
B - RENT LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12,659	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	124,843	2.00
3.00		0.00	0	0	3.00
TOTALS			0	137,502	
C - COMMUNITY RELATIONS					
1.00	MARKETING	194.02	302,745	58,563	1.00
TOTALS			302,745	58,563	
D - TRANSPORTATION					
1.00	CLINIC	90.00	18,466	108,247	1.00
TOTALS			18,466	108,247	
500.00	Grand Total: Increases		321,211	304,312	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
B - RENT LEASE							
1.00		0.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	132,091	10		2.00
3.00	OPERATION OF PLANT	7.00	0	5,411	10		3.00
	TOTALS		0	137,502			
C - COMMUNITY RELATIONS							
1.00	ADMINISTRATIVE & GENERAL	5.00	302,745	58,563	0		1.00
	TOTALS		302,745	58,563			
D - TRANSPORTATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	18,466	108,247	0		1.00
	TOTALS		18,466	108,247			
500.00	Grand Total: Decreases		321,211	304,312			500.00

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
B - RENT LEASE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12,659		0.00	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	124,843	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00	0	132,091	2.00
3.00		0.00	0	0		7.00	0	5,411	3.00
	TOTALS		0	137,502	TOTALS		0	137,502	
C - COMMUNITY RELATIONS									
1.00	MARKETING	194.02	302,745	58,563	ADMINISTRATIVE & GENERAL	5.00	302,745	58,563	1.00
	TOTALS		302,745	58,563	TOTALS		302,745	58,563	
D - TRANSPORTATION									
1.00	CLINIC	90.00	18,466	108,247	ADMINISTRATIVE & GENERAL	5.00	18,466	108,247	1.00
	TOTALS		18,466	108,247	TOTALS		18,466	108,247	
500.00	Grand Total: Increases		321,211	304,312	Grand Total: Decreases		321,211	304,312	500.00

	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	2,240,512	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,349,308	0	0	0	3.00
4.00	Building Improvements	412,122	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	2,006,845	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,008,787	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,008,787	0	0	0	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,240,512	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	19,349,308	0			3.00
4.00	Building Improvements	412,122	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	2,006,845	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	24,008,787	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	24,008,787	0			10.00

Provider CCN: 144034

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

Worksheet A-7
 Part II
 Date/Time Prepared:
 10/23/2015 10:44 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,082,241	0	0	51,561	1,219,170	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	285,428	0	0	16,494	0	2.00
3.00	Total (sum of lines 1-2)	1,367,669	0	0	68,055	1,219,170	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	2,352,972				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	301,922				2.00
3.00	Total (sum of lines 1-2)	0	2,654,894				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

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

Worksheet A-7
Part III
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL	
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance
		1.00	2.00	3.00	4.00	5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0 2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0 3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL	
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,108,422	12,659 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	236,276	124,843 2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,344,698	137,502 3.00
Cost Center Description		SUMMARY OF CAPITAL				
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)
		11.00	12.00	13.00	14.00	15.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	51,561	1,219,170	0	2,391,812 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,494	0	0	377,613 2.00
3.00	Total (sum of lines 1-2)	0	68,055	1,219,170	0	2,769,425 3.00

Line #	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	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00		0 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00	Investment income - other (chapter 2)		0		0.00		0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00		0 4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-51,680	ADMINISTRATIVE & GENERAL	5.00		0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00		0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00		0 7.00
8.00	Television and radio service (chapter 21)		0		0.00		0 8.00
9.00	Parking lot (chapter 21)		0		0.00		0 9.00
10.00	Provider-based physician adjustment	A-8-2	-2,882,881				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	56,671				0 12.00
13.00	Laundry and linen service		0		0.00		0 13.00
14.00	Cafeteria-employees and guests	A	-4,339	DIETARY	10.00		0 14.00
15.00	Rental of quarters to employee and others		0		0.00		0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00		0 16.00
17.00	Sale of drugs to other than patients		0		0.00		0 17.00
18.00	Sale of medical records and abstracts		0		0.00		0 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00		0 19.00
20.00	Vending machines		0		0.00		0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	B	26,181	CAP REL COSTS-BLDG & FIXT	1.00		9 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	B	-49,152	CAP REL COSTS-MVBLE EQUIP	2.00		9 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00
33.00	PHYSICIAN RECRUITING	B	-18,500	ADMINISTRATIVE & GENERAL	5.00		0 33.00
34.00	PHYSICIAN COSTS	B	-15,173	ADULTS & PEDIATRICS	30.00		0 34.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7	Ref.
	1.00	2.00	3.00	4.00	5.00	
35.00 LEGAL FEES	B	-717,256	ADMINISTRATIVE & GENERAL	5.00		0 35.00
36.00 MISC REVENUE	A	-31,222	ADMINISTRATIVE & GENERAL	5.00		0 36.00
37.00 PT TRANSPORTATION	B	-2,108	ADMINISTRATIVE & GENERAL	5.00		0 37.00
38.00 PT TRANSPORTATION	B	135	ADULTS & PEDIATRICS	30.00		0 38.00
39.00 MARKETING	B	-36,202	ADMINISTRATIVE & GENERAL	5.00		0 39.00
40.00		0		0.00		0 40.00
41.00 REBATES OFFSET FOR INFO ONLY	A	51,680	ADMINISTRATIVE & GENERAL	5.00		0 41.00
42.00		0		0.00		0 42.00
43.00		0		0.00		0 43.00
44.00 DONATIONS	B	-18,597	ADMINISTRATIVE & GENERAL	5.00		0 44.00
45.00 PHYSICIAN BILLING	B	-97,528	ADMINISTRATIVE & GENERAL	5.00		0 45.00
46.00		0		0.00		0 46.00
47.00 LOBBYING	B	-7,970	ADMINISTRATIVE & GENERAL	5.00		0 47.00
48.00 BAD DEBT	B	-840,884	ADMINISTRATIVE & GENERAL	5.00		0 48.00
49.00		0		0.00		0 49.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-4,638,825				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: 144034

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

Worksheet A-8-1

Date/Time Prepared: 10/23/2015 10:44 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	1,068,191	1,025,520
2.00	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	160,485
3.00	4.00	EMPLOYEE BENEFITS	WORKERS COMP INSURANCE	447,304	247,991
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	73,217	98,045
5.00	0			0	1,532,041

* 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	0.00	UNIVERSAL HEALT	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 144034

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

Worksheet A-8-1

Date/Time Prepared:
10/23/2015 10:44 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	42,671	0	1.00
2.00	-160,485	0	2.00
3.00	199,313	0	3.00
4.00	-24,828	0	4.00
5.00	56,671		5.00

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

Related Organization(s) and/or Home Office	Type of Business
	6.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOSPITAL	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: 144034

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

Worksheet A-8-2

Date/Time Prepared:
10/23/2015 10:44 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,293,690	2,293,690	0	0	0	1.00
2.00	90.00	AGGREGATE-CLINIC	589,191	589,191	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			2,882,881	2,882,881	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,293,690	1.00
2.00	90.00	AGGREGATE-CLINIC	0	0	0	589,191	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	2,882,881	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B
Part I
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,391,812	2,391,812			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	377,613		377,613		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,631,738	0	0	3,631,738	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,556,669	413,636	65,304	518,565	5.00
7.00 00700	OPERATION OF PLANT	1,194,317	146,435	23,119	98	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	211,747	30,148	4,760	0	8.00
9.00 00900	HOUSEKEEPING	580,540	14,397	2,273	0	9.00
10.00 01000	DIETARY	644,783	119,674	18,894	69,542	10.00
13.00 01300	NURSING ADMINISTRATION	896,690	17,455	2,756	236,494	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	359,776	16,756	2,645	59,618	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,472,133	1,150,203	181,590	1,870,449	30.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	80,235	5,767	911	0	60.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	563,306	12,977	2,049	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,560,136	186,261	29,406	369,703	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,521,495	2,113,709	333,707	3,124,469	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	EDUCATION	1,668,601	276,945	43,723	427,127	194.01
194.02 07952	MARKETING	361,308	1,158	183	80,142	194.02
194.03 07953	PHP MEALS	0	0	0	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	25,551,404	2,391,812	377,613	3,631,738	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B
Part I
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,554,174					5.00
7.00	00700	295,837	1,659,806				7.00
8.00	00800	53,498	27,318	327,471			8.00
9.00	00900	129,531	13,045	0	739,786		9.00
10.00	01000	184,987	108,441	0	49,537	1,195,858	10.00
13.00	01300	250,164	15,817	0	7,225	0	13.00
16.00	01600	95,172	15,183	0	6,936	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,315,209	1,042,241	327,471	476,112	1,195,858	30.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	18,851	5,226	0	2,387	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	125,437	11,759	0	5,372	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	465,347	168,778	0	77,100	0	90.00
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
118.00		3,934,033	1,407,808	327,471	624,669	1,195,858	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	524,102	250,949	0	114,638	0	194.01
194.02	07952	96,039	1,049	0	479	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,554,174	1,659,806	327,471	739,786	1,195,858	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B
Part I
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	1,426,601					13.00
16.00	01600	0	556,086				16.00
17.00	01700	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,426,601	556,086	0	18,013,953	0	30.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	113,377	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	720,900	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	2,856,731	0	90.00
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,426,601	556,086	0	21,704,961	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	3,306,085	0	194.01
194.02	07952	0	0	0	540,358	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,426,601	556,086	0	25,551,404	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B
Part I
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)		118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	EDUCATION	194.01
194.02	07952	MARKETING	194.02
194.03	07953	PHP MEALS	194.03
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	TOTAL (sum lines 118-201)		202.00

Provider CCN: 144034

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

Worksheet Non-CMS W

Date/Time Prepared:
 10/23/2015 10:44 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	P	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
13.00	NURSING ADMINISTRATION	P	PATIENT DAYS	13.00
16.00	MEDICAL RECORDS & LIBRARY	P	PATIENT DAYS	16.00
17.00	SOCIAL SERVICE	P	PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B
Part II
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
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	28,102	413,636	65,304	507,042 5.00
7.00 00700	OPERATION OF PLANT	0	146,435	23,119	169,554 0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	30,148	4,760	34,908 0 8.00
9.00 00900	HOUSEKEEPING	0	14,397	2,273	16,670 0 9.00
10.00 01000	DIETARY	0	119,674	18,894	138,568 0 10.00
13.00 01300	NURSING ADMINISTRATION	0	17,455	2,756	20,211 0 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	16,756	2,645	19,401 0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0 0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	1,150,203	181,590	1,331,793 0 30.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0 0 46.00
ANCILLARY SERVICE COST CENTERS					
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0 0 54.00
60.00 06000	LABORATORY	0	5,767	911	6,678 0 60.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0 0 67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0 0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0 0 70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	12,977	2,049	15,026 0 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	186,261	29,406	215,667 0 90.00
91.00 09100	EMERGENCY	0	0	0	0 0 91.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	28,102	2,113,709	333,707	2,475,518 0 118.00
NONREIMBURSABLE COST CENTERS					
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0 0 192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0 0 194.00
194.01 07951	EDUCATION	0	276,945	43,723	320,668 0 194.01
194.02 07952	MARKETING	0	1,158	183	1,341 0 194.02
194.03 07953	PHP MEALS	0	0	0	0 0 194.03
200.00	Cross Foot Adjustments				0 200.00
201.00	Negative Cost Centers		0	0	0 0 201.00
202.00	TOTAL (sum lines 118-201)	28,102	2,391,812	377,613	2,797,527 0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B
Part II
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	507,042					5.00
7.00	00700	32,937	202,491				7.00
8.00	00800	5,956	3,333	44,197			8.00
9.00	00900	14,421	1,591	0	32,682		9.00
10.00	01000	20,596	13,229	0	2,188	174,581	10.00
13.00	01300	27,852	1,930	0	319	0	13.00
16.00	01600	10,596	1,852	0	306	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	257,765	127,150	44,197	21,036	174,581	30.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	2,099	638	0	105	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	13,966	1,435	0	237	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	51,810	20,590	0	3,406	0	90.00
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
118.00		437,998	171,748	44,197	27,597	174,581	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	58,351	30,615	0	5,064	0	194.01
194.02	07952	10,693	128	0	21	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		507,042	202,491	44,197	32,682	174,581	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B
Part II
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	50,312					13.00
16.00	01600	0	32,155				16.00
17.00	01700	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	50,312	32,155	0	2,038,989	0	30.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	9,520	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	30,664	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	291,473	0	90.00
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
118.00		50,312	32,155	0	2,370,646	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	414,698	0	194.01
194.02	07952	0	0	0	12,183	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		50,312	32,155	0	2,797,527	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B
Part II
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	EDUCATION	194.01
194.02	07952	MARKETING	194.02
194.03	07953	PHP MEALS	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

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

Worksheet B-1

Date/Time Prepared:
10/23/2015 10:44 am

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	109,484			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		109,484		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,719,209		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,934	18,934	1,958,928	5.00
7.00	00700	OPERATION OF PLANT	6,703	6,703	370	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,380	1,380	0	8.00
9.00	00900	HOUSEKEEPING	659	659	0	9.00
10.00	01000	DIETARY	5,478	5,478	262,700	10.00
13.00	01300	NURSING ADMINISTRATION	799	799	893,377	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	767	767	225,213	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,650	52,650	7,065,777	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	264	264	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	594	594	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,526	8,526	1,396,588	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,754	96,754	11,802,953	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07951	EDUCATION	12,677	12,677	1,613,511	194.01
194.02	07952	MARKETING	53	53	302,745	194.02
194.03	07953	PHP MEALS	0	0	0	194.03
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per wkst. B, Part I)	2,391,812	377,613	3,631,738	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	21.846224	3.449025	0.264719	203.00
204.00		Cost to be allocated (per wkst. B, Part II)			0	204.00
205.00		Unit cost multiplier (wkst. B, Part II)			0.000000	205.00

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (PATIENT DAYS)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	83,847					7.00
8.00	00800	1,380	37,545				8.00
9.00	00900	659	0	81,808			9.00
10.00	01000	5,478	0	5,478	112,635		10.00
13.00	01300	799	0	799	0	37,545	13.00
16.00	01600	767	0	767	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	52,650	37,545	52,650	112,635	37,545	30.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	264	0	264	0	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	594	0	594	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	8,526	0	8,526	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
118.00		71,117	37,545	69,078	112,635	37,545	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	12,677	0	12,677	0	0	194.01
194.02	07952	53	0	53	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		1,659,806	327,471	739,786	1,195,858	1,426,601	202.00
203.00		19.795652	8.722093	9.042954	10.617108	37.997097	203.00
204.00		202,491	44,197	32,682	174,581	50,312	204.00
205.00		2.415006	1.177174	0.399496	1.549971	1.340045	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

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

Worksheet B-1
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,545	16.00
17.00	01700	SOCIAL SERVICE	0 37,545	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	37,545	30.00
46.00	04600	OTHER LONG TERM CARE	0 0	46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 0	54.00
60.00	06000	LABORATORY	0 0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0 0	67.00
69.00	06900	ELECTROCARDIOLOGY	0 0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0 0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0 0	90.00
91.00	09100	EMERGENCY	0 0	91.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)		37,545 37,545	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0 0	194.00
194.01	07951	EDUCATION	0 0	194.01
194.02	07952	MARKETING	0 0	194.02
194.03	07953	PHP MEALS	0 0	194.03
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)		556,086 0	202.00
203.00	Unit cost multiplier (wkst. B, Part I)		14.811187 0.000000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)		32,155 0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)		0.856439 0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C
Part I
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance		Total Costs	
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,013,953		18,013,953	0	18,013,953	30.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00	06000	LABORATORY	113,377		113,377	0	113,377	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	720,900		720,900	0	720,900	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,856,731		2,856,731	0	2,856,731	90.00
91.00	09100	EMERGENCY	0		0	0	0	91.00
200.00		Subtotal (see instructions)	21,704,961	0	21,704,961	0	21,704,961	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	21,704,961	0	21,704,961	0	21,704,961	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C
Part I
Date/Time Prepared:
10/23/2015 10:44 am

		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			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,353,838		55,353,838		30.00
46.00	04600	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	572,539	8	572,547	0.198022	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,019,888	0	2,019,888	0.356901	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	8,240,147	8,240,147	0.346684	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
200.00		Subtotal (see instructions)	57,946,265	8,240,155	66,186,420		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	57,946,265	8,240,155	66,186,420		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C
Part I
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
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: 144034

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

Worksheet D
Part I
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		Title XIX			Hospital	Cost		
		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)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,038,989	0	2,038,989	37,545	54.31	30.00	
200.00	Total (lines 30-199)	2,038,989		2,038,989	37,545		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	23,453	1,273,732					30.00
200.00	Total (lines 30-199)	23,453	1,273,732					200.00

APPORIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144034

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

Worksheet D
Part II
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		Title XIX			Hospital	Cost		
		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	0	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	9,520	572,547	0.016627	324,610	5,397	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,664	2,019,888	0.015181	1,145,208	17,385	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	291,473	8,240,147	0.035372	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
200.00		Total (lines 50-199)	331,657	10,832,582		1,469,818	22,782	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D
Part III
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		Title XIX			Hospital	Cost	Total Costs (sum of cols. 1 through 3, minus col. 4)
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	5.00	
		1.00	2.00	3.00	4.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
200.00		Total (lines 30-199)	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)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	37,545	0.00	23,453	0	30.00
200.00		Total (lines 30-199)	37,545		23,453	0	200.00
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D
Part IV
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description	Title XIX			Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
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: 144034

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

Worksheet D
Part IV
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description		Title XIX			Hospital		Cost	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	572,547	0.000000	0.000000	324,610	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,019,888	0.000000	0.000000	1,145,208	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	8,240,147	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
200.00		Total (lines 50-199)	0	10,832,582			1,469,818	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D
Part IV
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description			Title XIX			Hospital		Cost	
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
			11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D
Part IV
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description			PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
			23.00	24.00			
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	06000	LABORATORY	0	0			60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0			90.00
91.00	09100	EMERGENCY	0	0			91.00
200.00		Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

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

Worksheet D-1

Date/Time Prepared:
10/23/2015 10:44 am

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)			37,545 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			37,545 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)			37,545 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)			23,453 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)			18,013,953 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)			18,013,953 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)			18,013,953 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)			479.80 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			11,252,749 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)			11,252,749 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

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

Worksheet D-1

Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description	Title XIX			Hospital		Program Cost (col. 3 x col. 4)	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days			
	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)					473,006		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,725,755		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

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

Worksheet D-1
Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description	Cost	Title XIX		Hospital	Cost	
		Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,038,989	18,013,953	0.113189	0	0	90.00
91.00 Nursing School cost	0	18,013,953	0.000000	0	0	91.00
92.00 Allied health cost	0	18,013,953	0.000000	0	0	92.00
93.00 All other Medical Education	0	18,013,953	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 144034

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

Worksheet D-3

Date/Time Prepared:
10/23/2015 10:44 am

Cost Center Description	Title XIX	Hospital	Cost	
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS		31,383,761		30.00
ANCILLARY SERVICE COST CENTERS				
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00 06000 LABORATORY	0.198022	324,610	64,280	60.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.356901	1,145,208	408,726	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0.346684	0	0	90.00
91.00 09100 EMERGENCY	0.000000	0	0	91.00
200.00 Total (sum of lines 50-94 and 96-98)		1,469,818	473,006	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)		1,469,818		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 144034

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

Worksheet E-3
Part VII
Date/Time Prepared:
10/23/2015 10:44 am

		Title XIX		Hospital		Cost	
				Inpatient	Outpatient		
				1.00	2.00		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES							
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient hospital/SNF/NF services			11,725,755			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)			11,725,755	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)			11,725,755	0		7.00
COMPUTATION OF LESSER OF COST OR CHARGES							
Reasonable Charges							
8.00	Routine service charges			31,383,761			8.00
9.00	Ancillary service charges			1,469,818	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)			32,853,579	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)			32,853,579		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			21,127,824		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			0		0	18.00
19.00	Interns and Residents (see instructions)			0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)			0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)			11,725,755		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		0	24.00
25.00	Capital exception payments (see instructions)			0		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)			11,725,755		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT							
30.00	Excess of reasonable cost (from line 18)			0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			11,725,755		0	31.00
32.00	Deductibles			0		0	32.00
33.00	Coinsurance			0		0	33.00
34.00	Allowable bad debts (see instructions)			0		0	34.00
35.00	Utilization review			0		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			11,725,755		0	36.00
37.00	ELIMINATE SETTLEMENT			18,895,406		0	37.00
38.00	Subtotal (line 36 ± line 37)			30,621,161		0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)			0		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)			30,621,161		0	40.00
41.00	Interim payments			30,621,161		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
OVERRIDES							
109.00	Override Ancillary service charges (line 9)			0		0	109.00

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

Provider CCN: 144034

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

Worksheet G

Date/Time Prepared:
10/23/2015 10:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-147,198	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	6,765,188	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	74,485	0	0	0	7.00
8.00	Prepaid expenses	175,994	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,868,469	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,240,512	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	25,326,471	0	0	0	15.00
16.00	Accumulated depreciation	-4,732,065	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,445,400	0	0	0	23.00
24.00	Accumulated depreciation	-1,370,788	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)	23,909,530	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	61,444,716	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	61,444,716	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	92,222,715	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	593,122	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,990,802	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	32,715,288	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)	36,299,212	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,299,212	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	55,923,503				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)	55,923,503	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	92,222,715	0	0	0	60.00

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital	55,353,838		55,353,838	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	0		0	9.00
10.00 Total general inpatient care services (sum of lines 1-9)	55,353,838		55,353,838	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)	55,353,838		55,353,838	17.00
18.00 Ancillary services	2,821,734	0	2,821,734	18.00
19.00 Outpatient services	0	8,240,155	8,240,155	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	0	0	0	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	58,175,572	8,240,155	66,415,727	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per wkst. A, column 3, line 200)		30,190,229		29.00
30.00 ADD (SPECIFY)	0			30.00
31.00	0			31.00
32.00	0			32.00
33.00	0			33.00
34.00	0			34.00
35.00	0			35.00
36.00 Total additions (sum of lines 30-35)		0		36.00
37.00 DEDUCT (SPECIFY)	0			37.00
38.00	0			38.00
39.00	0			39.00
40.00	0			40.00
41.00	0			41.00
42.00 Total deductions (sum of lines 37-41)		0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		30,190,229		43.00

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	66,415,727	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,090,489	2.00
3.00	Net patient revenues (line 1 minus line 2)	45,325,238	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	30,190,229	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,135,009	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	2,667,774	24.00
25.00	Total other income (sum of lines 6-24)	2,667,774	25.00
26.00	Total (line 5 plus line 25)	17,802,783	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	17,802,783	29.00