

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: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/5/2015 8:58 am
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<b>PART I - COST REPORT STATUS</b>			
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: 11/5/2015	Time: 8:58 am
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 GARFIELD PARK HOSPITAL ( 144039 ) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	0	0	0	455,505	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	0	0	0	455,505	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 144039		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 11/5/2015 8:55 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 520 NORTH RIDGEWAY AVE			PO Box:						1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60624		County: COOK		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		GARFIELD PARK HOSPITAL		144039	16580	4	06/27/2013	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							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				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.						2		N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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	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	0	25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/5/2015 8:55 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)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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
<b>Teaching Hospitals</b>						
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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
			Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			N		0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)					0	76.00
						1.00	
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N			81.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00

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		V	XIX		
		1.00	2.00		
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		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
<b>Rural Providers</b>					
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.	N	N	N	N
					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
<b>Miscellaneous Cost Reporting Information</b>					
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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	33,198	118.01
					1.00 2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
<b>Transplant Center Information</b>					
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: 144039		Period: From 07/01/2014 To 06/30/2015		Worksheet S-2 Part I Date/Time Prepared: 11/5/2015 8:55 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	
<b>All Providers</b>							
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, INC	Contractor's Name: HIGHMARK		Contractor's Number: 12001		141.00	
142.00	Street: 367 S. GULPH RD	PO Box:				142.00	
143.00	City: KING OF PRUSSIA	State: PA		Zip Code: 19406		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00	
						1.00	
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	
		1.00		2.00		3.00	
						Title XIX	
						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	N	155.00
156.00	Subprovider - IPF	N	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	N	157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00
161.00	CMHC		N	N	N	N	161.00
						1.00	
<b>Multi campus</b>							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		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	
						1.00	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/5/2015 8:55 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)			N	171.00



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/5/2015 8:55 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/5/2015 8:55 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 Y	2.00	3.00 Y	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved 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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?	Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2012		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
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		SMI TH	41.00
42.00	Enter the employer/company name of the cost report preparer.	UNIVERSAL HEALTH SERVICES, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-312-5742		KEVIN.SMI TH@UHSI NC.COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144039

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/5/2015 8:55 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	88	32,120	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)		88	32,120	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)		88	32,120	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		88				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: 144039

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/5/2015 8:55 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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	5,638	7,684			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	5,638	7,684			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	5,638	7,684	0.00	85.03	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	85.03	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144039

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/5/2015 8:55 am

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	492	768	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	0	492	768	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144039

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

Worksheet A  
Date/Time Prepared:  
11/5/2015 8:55 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		712,385	712,385	0	712,385	1.00
2.00	00200		213,861	213,861	21,695	235,556	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	82,419	1,115,598	1,198,017	0	1,198,017	4.00
5.00	00500	1,222,983	618,253	1,841,236	-58,725	1,782,511	5.00
7.00	00700	171,965	372,951	544,916	0	544,916	7.00
8.00	00800	0	74,122	74,122	0	74,122	8.00
9.00	00900	0	118,828	118,828	0	118,828	9.00
10.00	01000	108,788	134,903	243,691	150	243,841	10.00
13.00	01300	506,796	7,407	514,203	0	514,203	13.00
16.00	01600	42,632	51,774	94,406	0	94,406	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,828,486	1,267,684	3,096,170	-74,392	3,021,778	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	162,465	2,703	165,168	74,392	239,560	90.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		4,126,534	4,690,469	8,817,003	-36,880	8,780,123	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	36,880	36,880	194.00
194.01	07951	51,886	1,466	53,352	0	53,352	194.01
194.02	07953	0	0	0	0	0	194.02
200.00		4,178,420	4,691,935	8,870,355	0	8,870,355	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144039

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

Worksheet A  
Date/Time Prepared:  
11/5/2015 8:55 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	712,385	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	235,556	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,862	1,192,155	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-43,151	1,739,360	5.00
7.00	00700	OPERATION OF PLANT	0	544,916	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,122	8.00
9.00	00900	HOUSEKEEPING	0	118,828	9.00
10.00	01000	DIETARY	0	243,841	10.00
13.00	01300	NURSING ADMINISTRATION	0	514,203	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	94,406	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-849,114	2,172,664	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
60.00	06000	LABORATORY	0	0	60.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	239,560	90.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-898,127	7,881,996	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	MARKETING	0	36,880	194.00
194.01	07951	EDUCATION	0	53,352	194.01
194.02	07953	PHP MEALS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-898,127	7,972,228	200.00



RECLASSIFICATIONS

Provider CCN: 144039

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

Worksheet A-6

Date/Time Prepared:  
11/5/2015 8:55 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENT LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	21,695	1.00
2.00	DIETARY	10.00	0	150	2.00
	TOTALS		0	21,845	
B - MARKETING					
1.00	MARKETING	194.00	34,337	2,543	1.00
	TOTALS		34,337	2,543	
C - PSYCH TESTING					
1.00	CLINIC	90.00	54,226	20,166	1.00
	TOTALS		54,226	20,166	
500.00	Grand Total: Increases		88,563	44,554	500.00

Provider CCN: 144039

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

Worksheet A-6  
Date/Time Prepared:  
11/5/2015 8:55 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENT LEASE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	21,845	10		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	21,845			
B - MARKETING							
1.00	ADMINISTRATIVE & GENERAL	5.00	34,337	2,543	0		1.00
	TOTALS		34,337	2,543			
C - PSYCH TESTING							
1.00	ADULTS & PEDIATRICS	30.00	54,226	20,166	0		1.00
	TOTALS		54,226	20,166			
500.00	Grand Total: Decreases		88,563	44,554			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144039

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/5/2015 8:55 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144039

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/5/2015 8:55 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	423,334	0	0	21,695	267,356	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	212,138	0	0	1,723	0	2.00
3.00	Total (sum of lines 1-2)	635,472	0	0	23,418	267,356	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	712,385				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	213,861				2.00
3.00	Total (sum of lines 1-2)	0	926,246				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144039

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/5/2015 8:55 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	423,334	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	212,138	21,695	2.00
3.00	Total (sum of lines 1-2)	0	0	0	635,472	21,695	3.00
Cost Center Description		SUMMARY OF CAPITAL			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	21,695	267,356	0	712,385	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,723	0	0	235,556	2.00
3.00	Total (sum of lines 1-2)	0	23,418	267,356	0	947,941	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144039

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

Worksheet A-8

Date/Time Prepared:  
11/5/2015 8:55 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
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	-746		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	-845,360					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	-13,821					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests			0		0.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts			0		0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 MISC ADMIN	B	-7,504		ADMINISTRATIVE & GENERAL	5.00		0	33.00
33.01 BAD DEBT	A	67,580		ADMINISTRATIVE & GENERAL	5.00		0	33.01

Provider CCN: 144039      Period: From 07/01/2014 To 06/30/2015      Worksheet A-8  
 Date/Time Prepared: 11/5/2015 8:55 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
33.02	PHYSICIAN BILLING COST	A	-13,744	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	REBATES	A	746	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING	A	-35,689	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PART B PHYSICIAN COST	A	-3,754	ADULTS & PEDIATRICS	30.00	0	33.05
33.06			0		0.00	0	33.06
33.07	DONATIONS	A	-1,667	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PATIENT TRANSPORTATION	A	-44,168	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09			0		0.00	0	33.09
33.10			0		0.00	0	33.10
33.11			0		0.00	0	33.11
33.12			0		0.00	0	33.12
33.13			0		0.00	0	33.13
33.14			0		0.00	0	33.14
33.15			0		0.00	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-898,127				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: 144039

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

Worksheet A-8-1

Date/Time Prepared:  
11/5/2015 8:55 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	INTERCOMPANY INTEREST	0	-53,018 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	309,358	353,940 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP INS	10,387	16,249 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	0	16,395 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			319,745	333,566 5.00

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

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

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

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

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

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

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



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

Provider CCN: 144039

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

Worksheet A-8-1

Date/Time Prepared:  
11/5/2015 8:55 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	53,018	0		1.00
2.00	-44,582	0		2.00
3.00	-5,862	0		3.00
4.00	-16,395	0		4.00
5.00	-13,821			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144039

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

Worksheet A-8-2

Date/Time Prepared:  
11/5/2015 8:55 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	845,360	845,360	0	142,500	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			845,360	845,360	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	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	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	845,360		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	845,360		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144039

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

Worksheet B  
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	712,385	712,385			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	235,556		235,556		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,192,155	0	0	1,192,155	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,739,360	72,270	23,897	345,959	5.00
7.00 00700	OPERATION OF PLANT	544,916	111,911	37,004	50,051	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	74,122	5,145	1,701	0	8.00
9.00 00900	HOUSEKEEPING	118,828	4,079	1,349	0	9.00
10.00 01000	DIETARY	243,841	54,023	17,863	31,663	10.00
13.00 01300	NURSING ADMINISTRATION	514,203	9,690	3,204	147,504	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	94,406	8,357	2,763	12,408	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,172,664	421,198	139,273	516,405	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	239,560	17,248	5,703	63,069	90.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,881,996	703,921	232,757	1,167,059	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MARKETING	36,880	0	0	9,994	194.00
194.01 07951	EDUCATION	53,352	8,464	2,799	15,102	194.01
194.02 07953	PHP MEALS	0	0	0	0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	7,972,228	712,385	235,556	1,192,155	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144039

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	2,181,486				5.00
7.00	00700	OPERATION OF PLANT	280,235	1,024,117			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,502	9,976	121,446		8.00
9.00	00900	HOUSEKEEPING	46,810	7,908	0	178,974	9.00
10.00	01000	DIETARY	130,869	104,743	0	18,630	601,632
13.00	01300	NURSING ADMINISTRATION	254,136	18,788	0	3,342	0
16.00	01600	MEDICAL RECORDS & LIBRARY	44,428	16,204	0	2,882	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,224,165	816,647	121,446	145,253	483,504
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	LABORATORY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	122,652	33,441	0	5,948	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,133,797	1,007,707	121,446	176,055	483,504
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	MARKETING	17,658	0	0	0	0
194.01	07951	EDUCATION	30,031	16,410	0	2,919	0
194.02	07953	PHP MEALS	0	0	0	0	118,128
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,181,486	1,024,117	121,446	178,974	601,632

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144039

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

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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	950,867					13.00
16.00	01600	0	181,448				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	950,867	154,546	7,145,968	0	7,145,968	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	26,902	514,523	0	514,523	90.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		950,867	181,448	7,660,491	0	7,660,491	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	64,532	0	64,532	194.00
194.01	07951	0	0	129,077	0	129,077	194.01
194.02	07953	0	0	118,128	0	118,128	194.02
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		950,867	181,448	7,972,228	0	7,972,228	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144039

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

Worksheet B  
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,139	72,270	23,897	104,306	5.00
7.00 00700	OPERATION OF PLANT	0	111,911	37,004	148,915	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,145	1,701	6,846	8.00
9.00 00900	HOUSEKEEPING	0	4,079	1,349	5,428	9.00
10.00 01000	DIETARY	0	54,023	17,863	71,886	10.00
13.00 01300	NURSING ADMINISTRATION	0	9,690	3,204	12,894	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	8,357	2,763	11,120	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	421,198	139,273	560,471	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	17,248	5,703	22,951	90.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,139	703,921	232,757	944,817	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MARKETING	0	0	0	0	194.00
194.01 07951	EDUCATION	0	8,464	2,799	11,263	194.01
194.02 07953	PHP MEALS	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	8,139	712,385	235,556	956,080	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144039

Period:  
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	104,306				5.00	
7.00	00700	OPERATION OF PLANT	13,400	162,315			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,458	1,581	9,885		8.00	
9.00	00900	HOUSEKEEPING	2,238	1,253	0	8,919	9.00	
10.00	01000	DIETARY	6,258	16,601	0	928	10.00	
13.00	01300	NURSING ADMINISTRATION	12,152	2,978	0	167	13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	2,124	2,568	0	144	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	58,531	129,433	9,885	7,239	76,888	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
60.00	06000	LABORATORY	0	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	5,865	5,300	0	296	0	90.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	102,026	159,714	9,885	8,774	76,888	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	844	0	0	0	0	194.00
194.01	07951	EDUCATION	1,436	2,601	0	145	0	194.01
194.02	07953	PHP MEALS	0	0	0	0	18,785	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	104,306	162,315	9,885	8,919	95,673	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144039

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		13.00	16.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	28,191					13.00
16.00	01600	0	15,956				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	28,191	13,590	884,228	0	884,228	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	2,366	36,778	0	36,778	90.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		28,191	15,956	921,006	0	921,006	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	844	0	844	194.00
194.01	07951	0	0	15,445	0	15,445	194.01
194.02	07953	0	0	18,785	0	18,785	194.02
200.00				0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		28,191	15,956	956,080	0	956,080	202.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144039

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

Worksheet B-1

Date/Time Prepared:  
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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				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	53,446				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		53,446			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,096,001		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,422	5,422	1,188,646	-2,181,486	5,790,742
7.00 00700	OPERATION OF PLANT	8,396	8,396	171,965	0	743,882
8.00 00800	LAUNDRY & LINEN SERVICE	386	386	0	0	80,968
9.00 00900	HOUSEKEEPING	306	306	0	0	124,256
10.00 01000	DIETARY	4,053	4,053	108,788	0	347,390
13.00 01300	NURSING ADMINISTRATION	727	727	506,796	0	674,601
16.00 01600	MEDICAL RECORDS & LIBRARY	627	627	42,632	0	117,934
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	31,600	31,600	1,774,260	0	3,249,540
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00 06000	LABORATORY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	1,294	1,294	216,691	0	325,580
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	52,811	52,811	4,009,778	-2,181,486	5,664,151
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	MARKETING	0	0	34,337	0	46,874
194.01 07951	EDUCATION	635	635	51,886	0	79,717
194.02 07953	PHP MEALS	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	712,385	235,556	1,192,155		2,181,486
203.00	Unit cost multiplier (Wkst. B, Part I)	13.329061	4.407364	0.291053		0.376720
204.00	Cost to be allocated (per Wkst. B, Part II)			0		104,306
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.018013

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144039

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	
		7.00	8.00	9.00	10.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	39,628					7.00
8.00	00800	386	7,684				8.00
9.00	00900	306	0	38,936			9.00
10.00	01000	4,053	0	4,053	28,684		10.00
13.00	01300	727	0	727	0	7,684	13.00
16.00	01600	627	0	627	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	31,600	7,684	31,600	23,052	7,684	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	1,294	0	1,294	0	0	90.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		38,993	7,684	38,301	23,052	7,684	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	635	0	635	0	0	194.01
194.02	07953	0	0	0	5,632	0	194.02
200.00							200.00
201.00							201.00
202.00		1,024,117	121,446	178,974	601,632	950,867	202.00
203.00		25.843267	15.805049	4.596620	20.974481	123.746356	203.00
204.00		162,315	9,885	8,919	95,673	28,191	204.00
205.00		4.095967	1.286439	0.229068	3.335413	3.668792	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144039

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

Worksheet B-1

Date/Time Prepared:  
11/5/2015 8:55 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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
		12,953,227	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
		11,032,727	
<b>ANCILLARY SERVICE COST CENTERS</b>			
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
		1,920,500	
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		12,953,227	
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	MARKETING	194.00
194.01	07951	EDUCATION	194.01
194.02	07953	PHP MEALS	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		181,448	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.014008	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		15,956	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.001232	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144039

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/5/2015 8:55 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE	Total Costs	
					Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	7,145,968		7,145,968	0	7,145,968	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	0		0	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	514,523		514,523	0	514,523	90.00
200.00	Subtotal (see instructions)	7,660,491	0	7,660,491	0	7,660,491	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	7,660,491	0	7,660,491	0	7,660,491	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144039

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/5/2015 8:55 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,032,727		11,032,727		30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
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	0	0	0	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,920,500	1,920,500	0.267911	90.00
200.00		Subtotal (see instructions)	11,032,727	1,920,500	12,953,227		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,032,727	1,920,500	12,953,227		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144039

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

Worksheet C  
Part I  
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11/5/2015 8:55 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.000000			60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.267911			90.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144039

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

Worksheet C  
Part I  
Date/Time Prepared:  
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7,145,968		7,145,968	0	7,145,968 30.00
ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	0		0	0	0 60.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	514,523		514,523	0	514,523 90.00
200.00	Subtotal (see instructions)	7,660,491	0	7,660,491	0	7,660,491 200.00
201.00	Less Observation Beds	0		0		0 201.00
202.00	Total (see instructions)	7,660,491	0	7,660,491	0	7,660,491 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144039

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/5/2015 8:55 am

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	11,032,727		11,032,727			30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	0	0	0	0.000000	0.000000	60.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,920,500	1,920,500	0.267911	0.000000	90.00
200.00	Subtotal (see instructions)	11,032,727	1,920,500	12,953,227			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	11,032,727	1,920,500	12,953,227			202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144039

Period:  
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To 06/30/2015

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 144039		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part I Date/Time Prepared: 11/5/2015 8:55 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	884,228	0	884,228	7,684	115.07	30.00
200.00	Total (Lines 30-199)	884,228		884,228	7,684		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	0	0				
200.00	Total (Lines 30-199)	0	0				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 144039		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part II Date/Time Prepared: 11/5/2015 8:55 am	
Cost Center Description			Title XVIII		Hospital		PPS	
			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								
60.00	06000	LABORATORY	0	0	0.000000	0	0	60.00
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	0	0	0.000000	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	36,778	1,920,500	0.019150	0	0	90.00
200.00		Total (lines 50-199)	36,778	1,920,500		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144039		Period: From 07/01/2014 To 06/30/2015		Worksheet D Part III Date/Time Prepared: 11/5/2015 8:55 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,684	0.00	0	0	0	30.00
200.00		Total (lines 30-199)	7,684		0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144039

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/5/2015 8:55 am

Cost Center Description		Title XVIII				Hospital		PPS
		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								
60.00	06000	LABORATORY	0	0	0	0	60.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	90.00	
200.00		Total (lines 50-199)	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144039

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/5/2015 8:55 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0.000000	0.000000	0	60.00
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	0	0.000000	0.000000	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,920,500	0.000000	0.000000	0	90.00
200.00		Total (lines 50-199)	0	1,920,500			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144039

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

Worksheet D  
Part IV  
Date/Time Prepared:  
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00	06000 LABORATORY	0	0	0		60.00
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	0	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/5/2015 8:55 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,684	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,684	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		7,684	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)		0	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
<b>SWING BED ADJUSTMENT</b>				
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)		7,145,968	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)		7,145,968	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		7,145,968	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		929.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00



COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/5/2015 8:55 am
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144039		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/5/2015 8:55 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	884,228	7,145,968	0.123738	0	0	90.00
91.00	Nursing School cost	0	7,145,968	0.000000	0	0	91.00
92.00	Allied health cost	0	7,145,968	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,145,968	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/5/2015 8:55 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,684	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,684	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		7,684	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)		5,638	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
<b>SWING BED ADJUSTMENT</b>				
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)		7,145,968	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)		7,145,968	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		7,145,968	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		929.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,243,227	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,243,227	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144039		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
Date/Time Prepared: 11/5/2015 8:55 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						5,243,227	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144039		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/5/2015 8:55 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	884,228	7,145,968	0.123738	0	0	90.00
91.00	Nursing School cost	0	7,145,968	0.000000	0	0	91.00
92.00	Allied health cost	0	7,145,968	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,145,968	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/5/2015 8:55 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		8,070,590		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.000000	0	0	60.00
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	0.000000	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.267911	0	0	90.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part II Date/Time Prepared: 11/5/2015 8:55 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			0 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			21.052055 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$ .			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			0 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			0 18.00
19.00	Deductibles			0 19.00
20.00	Subtotal (line 18 minus line 19)			0 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			0 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			0 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			0 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
32.00	Interim payments			0 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144039	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 11/5/2015 8:55 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		5,243,227		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5,243,227	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5,243,227	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		8,070,590		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		8,070,590	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		8,070,590	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,827,363	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		5,243,227	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		5,243,227	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		5,243,227	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		5,243,227	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		5,243,227	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		5,243,227	0	40.00
41.00	Interim payments		4,787,722	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		455,505	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00



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

Provider CCN: 144039

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

Worksheet G

Date/Time Prepared:  
11/5/2015 8:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-24,110	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,693,044	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	55,241	0	0	0	7.00
8.00	Prepaid expenses	24,486	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,748,661	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	50,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	16,604,475	0	0	0	15.00
16.00	Accumulated depreciation	-1,022,852	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,300,375	0	0	0	23.00
24.00	Accumulated depreciation	-507,109	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)	16,424,889	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,173,550	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	390,437	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,438,741	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	25,287,487	0	0	0	43.00
44.00	Other current liabilities	-1	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	27,116,664	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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)	27,116,664	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-7,943,114				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)	-7,943,114	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,173,550	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144039

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

Worksheet G-1

Date/Time Prepared:  
11/5/2015 8:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-5,854,288			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,088,832				2.00
3.00	Total (sum of line 1 and line 2)		-7,943,120			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		-7,943,120			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-7,943,120			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 144039

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/5/2015 8:55 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	11,032,727		11,032,727	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,032,727		11,032,727	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)	11,032,727		11,032,727	17.00
18.00	Ancillary services	0		0	18.00
19.00	Outpatient services	0	1,920,500	1,920,500	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)	11,032,727	1,920,500	12,953,227	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		8,870,355		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	PHYSICAL REVENUE	757,246			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)		757,246		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		8,113,109		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144039

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

Worksheet G-3

Date/Time Prepared:  
11/5/2015 8:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	12,953,227	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,936,454	2.00
3.00	Net patient revenues (line 1 minus line 2)	6,016,773	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	8,113,109	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,096,336	5.00
<b>OTHER INCOME</b>			
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	7,504	24.00
25.00	Total other income (sum of lines 6-24)	7,504	25.00
26.00	Total (line 5 plus line 25)	-2,088,832	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,088,832	29.00