

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: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/19/2015 5:43 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/19/2015 Time: 5:43 pm
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 HOLY FAMILY MEDICAL CENTER (142011) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	512,928	82,612	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	512,928	82,612	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142011		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/19/2015 5:43 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 100 NORTH RIVER ROAD, SECOND FLOOR		PO Box:				1.00			
2.00	City: DES PLAINES		State: IL		Zip Code: 60016		County: COOK			
		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		HOLY FAMILY MEDICAL CENTER		142011	16974	2	03/01/2006	N P P	
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2014	12/31/2014		20.00
21.00	Type of Control (see instructions)						1		21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/19/2015 5:43 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 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		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted 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	
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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		71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			Y		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	

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		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N			109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
				1.00	2.00
				3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0		118.01
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00

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		1.00	2.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H082	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: PRESENCE HEALTH	Contractor's Name: NGS		Contractor's Number: 00131	
142.00	Street: 200 S. WACKER DRIVE	PO Box:			
143.00	City: CHI CAGO	State: IL	Zip Code: 60606	143.00	
		1.00	2.00		
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.	Y	145.00		
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N	146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00		
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
		1.00			
Multi campus					
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N			165.00
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
		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			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N			167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0
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: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/19/2015 5:43 pm
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			171.00
			N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/19/2015 5:43 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			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.	Y			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.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/17/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-2
Part II
Date/Time Prepared:
5/19/2015 5:43 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SANDI		COSLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	8158062327		SANDRA.COSLER@PRESENCEHEALTH.ORG	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/17/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SYSTEM DIR OF REIMBURSEMENT	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: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/19/2015 5:43 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	120	43,800	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)		120	43,800	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	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)		128	46,720	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)		128				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: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/19/2015 5:43 pm

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)	18,512	1,698	33,424			1.00
2.00 HMO and other (see instructions)	30	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			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	18,512	1,698	33,424			7.00
8.00 INTENSIVE CARE UNIT	1,032	91	2,220			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)	19,544	1,789	35,644	0.09	556.40	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)				0.09	556.40	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: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/19/2015 5:43 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	583	49	1,481	1.00	
2.00 HMO and other (see instructions)			1	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	583	49	1,481	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: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet A
Date/Time Prepared:
5/19/2015 5:43 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT		4,508,025	4,508,025	-2,875,194	1,632,831	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	0	4,847,505	4,847,505	2.00
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-131,449	-8,904	-140,353	0	-140,353	4.00
5.01 00540 NONPATIENT TELEPHONES	0	201,423	201,423	0	201,423	5.01
5.02 00550 DATA PROCESSING	0	0	0	0	0	5.02
5.03 00560 PURCHASING RECEIVING AND STORES	0	49,578	49,578	-11,499	38,079	5.03
5.04 00570 ADMITTING	0	0	0	0	0	5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE	161,692	75,654	237,346	-8,213	229,133	5.05
5.06 00590 ADMINISTRATIVE & GENERAL	4,098,637	12,439,478	16,538,115	-26,440	16,511,675	5.06
6.00 00600 MAINTENANCE & REPAIRS	444,240	371,001	815,241	-205	815,036	6.00
7.00 00700 OPERATION OF PLANT	375,200	2,990,922	3,366,122	-4,610	3,361,512	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	286,152	286,152	-108	286,044	8.00
9.00 00900 HOUSEKEEPING	927,337	674,978	1,602,315	-18,490	1,583,825	9.00
10.00 01000 DIETARY	643,972	1,385,462	2,029,434	-810,194	1,219,240	10.00
11.00 01100 CAFETERIA	0	0	0	798,846	798,846	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	622,148	128,005	750,153	-869	749,284	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	92,276	344,485	436,761	-414,568	22,193	14.00
15.00 01500 PHARMACY	1,046,323	3,722,659	4,768,982	-3,487,569	1,281,413	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	355,914	222,429	578,343	-7,202	571,141	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	2,298	2,298	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	11,989,464	5,203,855	17,193,319	-2,797,599	14,395,720	30.00
31.00 03100 INTENSIVE CARE UNIT	1,601,844	532,314	2,134,158	-188,254	1,945,904	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,110,779	1,339,896	2,450,675	-1,032,265	1,418,410	50.00
53.00 05300 ANESTHESIOLOGY	0	326,281	326,281	-16,376	309,905	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	482,420	230,877	713,297	-104,072	609,225	54.00
56.00 05600 RADIOISOTOPE	37,847	29,758	67,605	-13,819	53,786	56.00
57.00 05700 CT SCAN	138,306	65,247	203,553	-18,534	185,019	57.00
57.01 03630 ULTRA SOUND	166,526	46,692	213,218	-6,482	206,736	57.01
58.00 05800 MRI	39,217	12,512	51,729	-974	50,755	58.00
60.00 06000 LABORATORY	0	2,286,198	2,286,198	282	2,286,480	60.00
65.00 06500 RESPIRATORY THERAPY	3,064,197	1,086,317	4,150,514	-317,002	3,833,512	65.00
66.00 06600 PHYSICAL THERAPY	2,401,014	572,970	2,973,984	-32,785	2,941,199	66.00
69.00 06900 ELECTROCARDIOLOGY	65,198	22,895	88,093	-7,393	80,700	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	225,649	91,596	317,245	-12,988	304,257	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,824,001	2,824,001	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	579,808	579,808	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	3,669,660	3,669,660	73.00
74.00 07400 RENAL DIALYSIS	602,140	254,206	856,346	-75,326	781,020	74.00
76.00 03950 SUBSTANCE ABUSE	125,258	39,177	164,435	967,166	1,131,601	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	756,289	857,719	1,614,008	-536,181	1,077,827	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	66,657	-13,283	53,374	-6,340	47,034	90.00
90.02 09001 WOMENS DIAGNOSTIC CENTER	189,640	63,428	253,068	-9,108	243,960	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		848,907	848,907	-848,907	0	113.00
118.00 118.00 SUBTOTALS (SUM OF LINES 1-117)	31,698,735	41,288,909	72,987,644	0	72,987,644	118.00
NONREIMBURSABLE COST CENTERS						
200.00 200.00 TOTAL (SUM OF LINES 118-199)	31,698,735	41,288,909	72,987,644	0	72,987,644	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	104,698	1,737,529	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	384,701	5,232,206	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	240,528	100,175	4.00
5.01	00540	NONPATIENT TELEPHONES	0	201,423	5.01
5.02	00550	DATA PROCESSING	1,249,892	1,249,892	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	474,447	512,526	5.03
5.04	00570	ADMINITTING	0	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,627,424	1,856,557	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	-4,554,392	11,957,283	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	815,036	6.00
7.00	00700	OPERATION OF PLANT	0	3,361,512	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	286,044	8.00
9.00	00900	HOUSEKEEPING	0	1,583,825	9.00
10.00	01000	DIETARY	-15,924	1,203,316	10.00
11.00	01100	CAFETERIA	-332,617	466,229	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	749,284	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,740	104,933	14.00
15.00	01500	PHARMACY	0	1,281,413	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-780	570,361	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	2,298	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-27,347	14,368,373	30.00
31.00	03100	INTENSIVE CARE UNIT	185,137	2,131,041	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,418,410	50.00
53.00	05300	ANESTHESIOLOGY	-306,646	3,259	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	609,225	54.00
56.00	05600	RADIOISOTOPE	0	53,786	56.00
57.00	05700	CT SCAN	0	185,019	57.00
57.01	03630	ULTRA SOUND	0	206,736	57.01
58.00	05800	MRI	0	50,755	58.00
60.00	06000	LABORATORY	-164,568	2,121,912	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,833,512	65.00
66.00	06600	PHYSICAL THERAPY	-796	2,940,403	66.00
69.00	06900	ELECTROCARDIOLOGY	0	80,700	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	304,257	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,824,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	579,808	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,669,660	73.00
74.00	07400	RENAL DIALYSIS	0	781,020	74.00
76.00	03950	SUBSTANCE ABUSE	0	1,131,601	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,077,827	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	47,034	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	243,960	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,053,503	71,934,141	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118-199)	-1,053,503	71,934,141	200.00

RECLASSIFICATIONS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

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		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - RECLASS MOV EQUIPMENT DEPR EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,875,194	1.00	
	TOTALS		0	2,875,194		
B - RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	848,907	1.00	
	TOTALS		0	848,907		
C - RECLASS DIETARY COSTS						
1.00	CAFETERIA	11.00	253,487	545,359	1.00	
	TOTALS		253,487	545,359		
D - RECLASS SUPPLY COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,824,001	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	579,808	2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	219,499	3.00	
4.00	LABORATORY	60.00	0	284	4.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
	TOTALS		0	3,623,592		
E - RECLASS DRUG COSTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,669,660	1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,197	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
	TOTALS		0	3,698,857		
F - RECLASS RESIDENCY COSTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	2,298	0	1.00	
	TOTALS		2,298	0		
G - RECLASS RENTAL COSTS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,123,404	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	

RECLASSIFICATIONS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
	TOTALS		0	1,123,404		
H - RECLASS SUBSTANCE ABUSE						
1.00	SUBSTANCE ABUSE	76.00	693,351	273,815		1.00
	TOTALS		693,351	273,815		
500.00	Grand Total: Increases		949,136	12,989,128		500.00

RECLASSIFICATIONS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-6
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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - RECLASS MOV EQUIPMENT DEPR EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,875,194	9	1.00
	TOTALS		0	2,875,194		
B - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	848,907	11	1.00
	TOTALS		0	848,907		
C - RECLASS DIETARY COSTS						
1.00	DIETARY	10.00	253,487	545,359	0	1.00
	TOTALS		253,487	545,359		
D - RECLASS SUPPLY COSTS						
1.00	PURCHASING RECEIVING AND STORES	5.03	0	8	0	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	4,527	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.06	0	328	0	3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	8	0	4.00
6.00	HOUSEKEEPING	9.00	0	18,408	0	6.00
7.00	DIETARY	10.00	0	468	0	7.00
8.00	NURSING ADMINISTRATION	13.00	0	130	0	8.00
10.00	PHARMACY	15.00	0	14,955	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	1,649,462	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	171,182	0	12.00
13.00	OPERATING ROOM	50.00	0	999,715	0	13.00
14.00	ANESTHESIOLOGY	53.00	0	15,557	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	96,457	0	15.00
16.00	RADIOISOTOPE	56.00	0	11,090	0	16.00
17.00	CT SCAN	57.00	0	14,227	0	17.00
18.00	ULTRA SOUND	57.01	0	6,482	0	18.00
19.00	MRI	58.00	0	965	0	19.00
21.00	RESPIRATORY THERAPY	65.00	0	302,003	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	18,662	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	772	0	23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	9,130	0	24.00
25.00	RENAL DIALYSIS	74.00	0	73,681	0	25.00
26.00	HYPERBARIC OXYGEN THERAPY	76.98	0	204,893	0	26.00
27.00	CLINIC	90.00	0	3,536	0	27.00
28.00	WOMENS DIAGNOSTIC CENTER	90.02	0	6,946	0	28.00
	TOTALS		0	3,623,592		
E - RECLASS DRUG COSTS						
1.00	DIETARY	10.00	0	102	0	1.00
2.00		0.00	0	0	0	2.00
3.00	PHARMACY	15.00	0	3,469,635	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	155,858	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	16,525	0	5.00
6.00	OPERATING ROOM	50.00	0	18,854	0	6.00
7.00	ANESTHESIOLOGY	53.00	0	819	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,732	0	8.00
9.00	RADIOISOTOPE	56.00	0	57	0	9.00
10.00	CT SCAN	57.00	0	4,248	0	10.00
12.00	MRI	58.00	0	9	0	12.00
13.00	LABORATORY	60.00	0	2	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	11,339	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	508	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	416	0	16.00
17.00	RENAL DIALYSIS	74.00	0	1,628	0	17.00
18.00	HYPERBARIC OXYGEN THERAPY	76.98	0	15,515	0	18.00
19.00	CLINIC	90.00	0	591	0	19.00
20.00	WOMENS DIAGNOSTIC CENTER	90.02	0	19	0	20.00
	TOTALS		0	3,698,857		
F - RECLASS RESIDENCY COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.06	2,298	0	0	1.00
	TOTALS		2,298	0		
G - RECLASS RENTAL COSTS						
1.00	PURCHASING RECEIVING AND STORES	5.03	0	11,491	10	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	3,686	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.06	0	23,814	0	3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	197	0	4.00
5.00	OPERATION OF PLANT	7.00	0	4,610	0	5.00
6.00	LAUNDRY & LINEN SERVICE	8.00	0	108	0	6.00
7.00	HOUSEKEEPING	9.00	0	82	0	7.00
8.00	DIETARY	10.00	0	10,778	0	8.00
9.00	NURSING ADMINISTRATION	13.00	0	739	0	9.00

RECLASSIFICATIONS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	663,264	0		10.00
11.00	PHARMACY	15.00	0	2,979	0		11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,202	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	25,113	0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	547	0		14.00
15.00	OPERATING ROOM	50.00	0	13,696	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,883	0		16.00
17.00	RADIOISOTOPE	56.00	0	2,672	0		17.00
18.00	CT SCAN	57.00	0	59	0		18.00
20.00	RESPIRATORY THERAPY	65.00	0	3,660	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	13,615	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	6,205	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,858	0		23.00
24.00	RENAL DIALYSIS	74.00	0	17	0		24.00
25.00	HYPERBARIC OXYGEN THERAPY	76.98	0	315,773	0		25.00
26.00	CLINIC	90.00	0	2,213	0		26.00
27.00	WOMENS DIAGNOSTIC CENTER	90.02	0	2,143	0		27.00
	TOTALS		0	1,123,404			
H - RECLASS SUBSTANCE ABUSE							
1.00	ADULTS & PEDIATRICS	30.00	693,351	273,815	0		1.00
	TOTALS		693,351	273,815			
500.00	Grand Total: Decreases		949,136	12,989,128			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-7
Part I
Date/Time Prepared:
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	342,000	0	0	0	1.00
2.00	Land Improvements	4,077,827	0	0	0	2.00
3.00	Buildings and Fixtures	84,740,088	817,597	0	817,597	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	2,119,028	0	0	0	5.00
6.00	Movable Equipment	34,685,987	1,285,484	0	1,285,484	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	125,964,930	2,103,081	0	2,103,081	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	125,964,930	2,103,081	0	2,103,081	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	342,000	0			1.00
2.00	Land Improvements	4,077,827	0			2.00
3.00	Buildings and Fixtures	85,557,685	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	2,119,028	0			5.00
6.00	Movable Equipment	35,971,471	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	128,068,011	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	128,068,011	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-7
Part II
Date/Time Prepared:
5/19/2015 5:43 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	4,508,025	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,508,025	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	4,508,025				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,508,025				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-7
Part III
Date/Time Prepared:
5/19/2015 5:43 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	92,096,540	0	92,096,540	0.719122	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	35,971,471	0	35,971,471	0.280878	0	2.00
3.00	Total (sum of lines 1-2)	128,068,011	0	128,068,011	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,737,529	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,259,895	1,123,404	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,997,424	1,123,404	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,737,529	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	848,907	0	0	0	5,232,206	2.00
3.00	Total (sum of lines 1-2)	848,907	0	0	0	6,969,735	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-8

Date/Time Prepared:
5/19/2015 5:43 pm

Line #	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 #			
				3.00	4.00			
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00	Television and radio service (chapter 21)			0		0.00	0	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-869,227				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	253,850				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-332,617	CAFETERIA		11.00	0	14.00
15.00	Rental of quarters to employee and others			0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00	Sale of drugs to other than patients			0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-780	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00	Vending machines	B	-15,924	DIETARY		10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00	OFFSET SUBSTANCE ABUSE REVENUE	B	-755	ADULTS & PEDIATRICS		30.00	0	33.00
33.01	MISC ADMIN INCOME	B	-104,104	ADMINISTRATIVE & GENERAL		5.06	0	33.01

Provider CCN: 142011
 Period: From 01/01/2014 To 12/31/2014
 Worksheet A-8
 Date/Time Prepared: 5/19/2015 5:43 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.02 OFFSET INCOME TAX	A	-4,700	ADMINISTRATIVE & GENERAL	5.06	9 33.02
33.03		0		0.00	0 33.03
34.00 OFFSET FINANCE INTEREST INCOME	B	-13,621	ADMINISTRATIVE & GENERAL	5.06	0 34.00
35.00 OFFSET LAB INCOME	B	-17,030	LABORATORY	60.00	0 35.00
36.00 OFFSET PATIENT TRANSPORT INCOME	B	-11,295	ADMINISTRATIVE & GENERAL	5.06	0 36.00
37.00 OFFSET PT INCOME	B	-796	PHYSICAL THERAPY	66.00	0 37.00
38.00 OFFSET CHILDCARE INCOME	B	-26,856	ADMINISTRATIVE & GENERAL	5.06	0 38.00
39.00 CY PORTION OF 1995 LOSS	A	10,120	CAP REL COSTS-MVBLE EQUIP	2.00	9 39.00
39.01 CURRENT YEAR PORTION OF 1996 LOSS	A	4,680	CAP REL COSTS-MVBLE EQUIP	2.00	9 39.01
39.02 1977 & 1983 EXCESS INTEREST	A	43,296	CAP REL COSTS-MVBLE EQUIP	2.00	9 39.02
39.03 DEMOLITION ADD BACK	A	32,256	CAP REL COSTS-MVBLE EQUIP	2.00	9 39.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,053,503			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: 142011

Period: From 01/01/2014 To 12/31/2014

Worksheet A-8-1

Date/Time Prepared: 5/19/2015 5:43 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL	104,698	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	294,349	0
3.00	5.06	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	3,282,792	7,176,619
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	240,528	0
3.02	5.02	DATA PROCESSING	DATA PROCESSING	1,249,892	0
3.03	5.03	PURCHASING RECEIVING AND STO	PURCHASING	474,447	0
3.04	5.05	CASHIERING/ACCOUNTS RECEIVAB	PATIENT ACCTS	1,627,424	0
3.05	31.00	INTENSIVE CARE UNIT	ELECTRONIC ICU	185,137	0
3.06	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	82,740	0
3.07	60.00	LABORATORY	ALVERNO LAB	1,888,842	2,000,380
4.00	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,430,849	9,176,999

* 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	RESURRECTION HEALTH CARE	100.00	0.00	6.00
7.00	C	ALVERNO LAB	66.00	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: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-8-1

Date/Time Prepared:
5/19/2015 5:43 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	104,698	9		1.00
2.00	294,349	9		2.00
3.00	-3,893,827	0		3.00
3.01	240,528	0		3.01
3.02	1,249,892	0		3.02
3.03	474,447	0		3.03
3.04	1,627,424	0		3.04
3.05	185,137	0		3.05
3.06	82,740	0		3.06
3.07	-111,538	0		3.07
4.00	0	0		4.00
5.00	253,850			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-8-2

Date/Time Prepared:
5/19/2015 5:43 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	306,646	306,646	0	0	0	1.00
2.00	60.00	LABORATORY	36,000	36,000	0	0	0	2.00
3.00	5.06	ADMINISTRATIVE & GENERAL	419,716	419,716	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	83,500	0	83,500	177,200	668	4.00
5.00	5.06	ADMINISTRATIVE & GENERAL	252,106	0	252,106	177,200	2,017	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			1,097,968	762,362	335,606		2,685	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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	5.06	ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	56,908	2,845	0	0	0	4.00
5.00	5.06	ADMINISTRATIVE & GENERAL	171,833	8,592	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			228,741	11,437	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	53.00	ANESTHESIOLOGY	0	0	0	306,646	1.00
2.00	60.00	LABORATORY	0	0	0	36,000	2.00
3.00	5.06	ADMINISTRATIVE & GENERAL	0	0	0	419,716	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	56,908	26,592	26,592	4.00
5.00	5.06	ADMINISTRATIVE & GENERAL	0	171,833	80,273	80,273	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	228,741	106,865	869,227	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part I
Date/Time Prepared:
5/19/2015 5:43 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,737,529	1,737,529			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,232,206		5,232,206		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	100,175	2,119	6,382	108,676	4.00
5.01 00540	NONPATIENT TELEPHONES	201,423	13,835	41,660	0	256,918 5.01
5.02 00550	DATA PROCESSING	1,249,892	0	0	0	17,469 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	512,526	37,447	112,762	0	5,823 5.03
5.04 00570	ADMINISTRATIVE	0	0	0	0	0 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,856,557	0	0	552	13,044 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	11,957,283	438,367	1,320,057	13,985	45,421 5.06
6.00 00600	MAINTENANCE & REPAIRS	815,036	66,316	199,697	1,517	3,494 6.00
7.00 00700	OPERATION OF PLANT	3,361,512	252,319	759,807	1,281	4,891 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	286,044	29,455	88,697	0	0 8.00
9.00 00900	HOUSEKEEPING	1,583,825	20,843	62,763	3,166	1,863 9.00
10.00 01000	DIETARY	1,203,316	85,584	257,718	1,333	1,630 10.00
11.00 01100	CAFETERIA	466,229	0	0	865	2,329 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	749,284	0	0	2,124	466 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	104,933	41,486	124,927	315	2,329 14.00
15.00 01500	PHARMACY	1,281,413	34,203	102,995	3,572	5,124 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	570,361	22,201	66,854	1,215	17,004 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	2,298	0	0	8	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	14,368,373	198,872	598,861	38,572	64,056 30.00
31.00 03100	INTENSIVE CARE UNIT	2,131,041	22,810	68,687	5,469	1,165 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,418,410	166,267	500,679	3,792	20,498 50.00
53.00 05300	ANESTHESIOLOGY	3,259	656	1,975	0	1,630 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	609,225	44,338	133,513	1,647	19,799 54.00
56.00 05600	RADIOISOTOPE	53,786	7,699	23,184	129	0 56.00
57.00 05700	CT SCAN	185,019	3,033	9,132	472	0 57.00
57.01 03630	ULTRA SOUND	206,736	4,186	12,606	569	0 57.01
58.00 05800	MRI	50,755	0	0	134	466 58.00
60.00 06000	LABORATORY	2,121,912	38,214	115,072	0	13,743 60.00
65.00 06500	RESPIRATORY THERAPY	3,833,512	3,115	9,379	10,461	5,590 65.00
66.00 06600	PHYSICAL THERAPY	2,940,403	66,363	199,838	8,197	5,124 66.00
69.00 06900	ELECTROCARDIOLOGY	80,700	10,533	31,717	223	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	304,257	17,915	53,948	770	2,795 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,824,001	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	579,808	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,669,660	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	781,020	1,914	5,765	2,056	233 74.00
76.00 03950	SUBSTANCE ABUSE	1,131,601	52,511	158,125	2,795	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	1,077,827	17,675	53,225	2,582	466 76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	47,034	20,567	61,935	228	0 90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	243,960	16,686	50,246	647	466 90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	71,934,141	1,737,529	5,232,206	108,676	256,918 118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	71,934,141	1,737,529	5,232,206	108,676	256,918 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	1,267,361					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	26,077	694,635				5.03
5.04	00570	ADMINISTRATIVE	0	0	0			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	114,741	1,337	0	1,986,231		5.05
5.06	00590	ADMINISTRATIVE & GENERAL	385,950	29,104	0	0	14,190,167	5.06
6.00	00600	MAINTENANCE & REPAIRS	15,646	10,802	0	0	1,112,508	6.00
7.00	00700	OPERATION OF PLANT	5,215	8,328	0	0	4,393,353	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,215	39,579	0	0	448,990	8.00
9.00	00900	HOUSEKEEPING	5,215	15,516	0	0	1,693,191	9.00
10.00	01000	DIETARY	5,215	65,838	0	0	1,620,634	10.00
11.00	01100	CAFETERIA	5,215	0	0	0	474,638	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	231	0	0	752,105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,215	2,498	0	0	281,703	14.00
15.00	01500	PHARMACY	26,077	0	0	0	1,453,384	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114,741	0	0	0	792,376	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	2,306	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	73,017	24,222	0	581,920	15,947,893	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,917	0	48,537	2,279,626	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	67,801	2,605	0	105,951	2,286,003	50.00
53.00	05300	ANESTHESIOLOGY	0	3	0	25,434	32,957	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,111	2,114	0	26,107	1,008,854	54.00
56.00	05600	RADIO SOTOP	0	68	0	2,617	87,483	56.00
57.00	05700	CT SCAN	0	1,047	0	29,214	227,917	57.00
57.01	03630	ULTRA SOUND	0	37	0	16,860	240,994	57.01
58.00	05800	MRI	5,215	442	0	7,550	64,562	58.00
60.00	06000	LABORATORY	135,602	27,676	0	181,413	2,633,632	60.00
65.00	06500	RESPIRATORY THERAPY	26,077	9,034	0	278,527	4,175,695	65.00
66.00	06600	PHYSICAL THERAPY	52,155	522	0	67,825	3,340,427	66.00
69.00	06900	ELECTROCARDIOLOGY	0	24	0	10,717	133,914	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,646	992	0	15,467	411,790	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	363,207	0	133,522	3,320,730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	80,226	0	8,919	668,953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	360,114	4,029,774	73.00
74.00	07400	RENAL DIALYSIS	0	122	0	24,922	816,032	74.00
76.00	03950	SUBSTANCE ABUSE	0	397	0	28,456	1,373,885	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	5,258	0	20,999	1,178,032	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	325	0	4,533	134,622	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	5,215	1,164	0	6,627	325,011	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,267,361	694,635	0	1,986,231	71,934,141	118.00
NONREIMBURSABLE COST CENTERS								
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)	1,267,361	694,635	0	1,986,231	71,934,141	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL	14,190,167				5.06
6.00	00600	MAINTENANCE & REPAIRS	273,391	1,385,899			6.00
7.00	00700	OPERATION OF PLANT	1,079,636	296,485	5,769,474		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	110,336	34,611	183,297	777,234	8.00
9.00	00900	HOUSEKEEPING	416,090	24,491	129,703	0	2,263,475
10.00	01000	DIETARY	398,259	100,565	532,586	0	220,929
11.00	01100	CAFETERIA	116,639	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	184,825	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	69,227	48,748	258,168	0	107,094
15.00	01500	PHARMACY	357,159	40,190	212,845	0	88,293
16.00	01600	MEDICAL RECORDS & LIBRARY	194,721	26,087	138,156	0	57,310
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	567	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,919,070	233,683	1,237,575	577,635	513,376
31.00	03100	INTENSIVE CARE UNIT	560,202	26,803	141,945	55,661	58,882
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	561,769	195,371	1,034,677	80,353	429,209
53.00	05300	ANESTHESIOLOGY	8,099	771	4,081	0	1,693
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,919	52,099	275,911	9,363	114,455
56.00	05600	RADIOISOTOPE	21,498	9,047	47,910	0	19,874
57.00	05700	CT SCAN	56,009	3,564	18,873	5,519	7,829
57.01	03630	ULTRASOUND	59,223	4,919	26,050	6,400	10,806
58.00	05800	MRI	15,866	0	0	163	0
60.00	06000	LABORATORY	647,197	44,903	237,802	0	98,646
65.00	06500	RESPIRATORY THERAPY	1,026,148	3,660	19,383	677	8,040
66.00	06600	PHYSICAL THERAPY	820,887	77,979	412,974	18,890	171,312
69.00	06900	ELECTROCARDIOLOGY	32,908	12,376	65,544	707	27,189
70.00	07000	ELECTROENCEPHALOGRAPHY	101,195	21,051	111,487	918	46,247
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	816,046	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	164,391	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	990,289	0	0	0	0
74.00	07400	RENAL DIALYSIS	200,534	2,250	11,914	0	4,942
76.00	03950	SUBSTANCE ABUSE	337,623	61,702	326,773	0	135,553
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARI C OXYGEN THERAPY	289,493	20,769	109,993	17,487	45,628
76.99	07699	LI THOTRI PSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	33,082	24,168	127,991	298	53,094
90.02	09001	WOMENS DIAGNOSTIC CENTER	79,869	19,607	103,836	3,163	43,074
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,190,167	1,385,899	5,769,474	777,234	2,263,475
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	14,190,167	1,385,899	5,769,474	777,234	2,263,475

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,872,973					10.00
11.00	01100	CAFETERIA	0	591,277				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	9,726	0	946,656		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,604	0	0	769,544	14.00
15.00	01500	PHARMACY	0	17,661	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,742	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,780,629	310,499	0	717,038	0	30.00
31.00	03100	INTENSIVE CARE UNIT	92,344	29,753	0	68,708	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	25,316	0	58,463	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,111	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	700	0	0	0	56.00
57.00	05700	CT SCAN	0	1,917	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	3,569	0	0	0	57.01
58.00	05800	MRI	0	728	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	72,633	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	48,954	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,427	0	3,296	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,046	0	13,961	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	638,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	131,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	11,238	0	25,951	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	3,779	0	8,726	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	17,018	0	39,299	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,455	0	3,361	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	3,401	0	7,853	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,872,973	591,277	0	946,656	769,544	118.00
NONREIMBURSABLE COST CENTERS								
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)	2,872,973	591,277	0	946,656	769,544	202.00

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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
				15.00	16.00		17.00
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.01 00540 NONPATIENT TELEPHONES						5.01	
5.02 00550 DATA PROCESSING						5.02	
5.03 00560 PURCHASING RECEIVING AND STORES						5.03	
5.04 00570 ADMITTING						5.04	
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.05	
5.06 00590 ADMINISTRATIVE & GENERAL						5.06	
6.00 00600 MAINTENANCE & REPAIRS						6.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA						11.00	
12.00 01200 MAINTENANCE OF PERSONNEL						12.00	
13.00 01300 NURSING ADMINISTRATION						13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00	
15.00 01500 PHARMACY	2,169,532					15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1,220,392				16.00	
17.00 01700 SOCIAL SERVICE	0	0	0			17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	2,873		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	0	357,542	0	2,873	0	30.00	
31.00 03100 INTENSIVE CARE UNIT	0	29,822	0	0	0	31.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	65,099	0	0	0	50.00	
53.00 05300 ANESTHESIOLOGY	0	15,627	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	16,041	0	0	0	54.00	
56.00 05600 RADIOISOTOPE	0	1,608	0	0	0	56.00	
57.00 05700 CT SCAN	0	17,950	0	0	0	57.00	
57.01 03630 ULTRA SOUND	0	10,359	0	0	0	57.01	
58.00 05800 MRI	0	4,639	0	0	0	58.00	
60.00 06000 LABORATORY	0	111,465	0	0	0	60.00	
65.00 06500 RESPIRATORY THERAPY	0	171,135	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	41,674	0	0	0	66.00	
69.00 06900 ELECTROCARDIOLOGY	0	6,585	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	9,504	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	82,040	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,480	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	2,169,532	221,265	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	15,313	0	0	0	74.00	
76.00 03950 SUBSTANCE ABUSE	0	17,484	0	0	0	76.00	
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	12,903	0	0	0	76.98	
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	2,785	0	0	0	90.00	
90.02 09001 WOMENS DIAGNOSTIC CENTER	0	4,072	0	0	0	90.02	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE						113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		2,169,532	1,220,392	0	2,873	0
NONREIMBURSABLE COST CENTERS							
200.00	Cross Foot Adjustments				0	0	0
201.00	Negative Cost Centers		0	0	0	0	0
202.00	TOTAL (sum lines 118-201)		2,169,532	1,220,392	0	2,873	0

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00540				5.01
5.02	00550				5.02
5.03	00560				5.03
5.04	00570				5.04
5.05	00580				5.05
5.06	00590				5.06
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	26,597,813	-2,873	26,594,940	30.00
31.00	03100	3,343,746	0	3,343,746	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	4,736,260	0	4,736,260	50.00
53.00	05300	63,228	0	63,228	53.00
54.00	05400	1,733,753	0	1,733,753	54.00
56.00	05600	188,120	0	188,120	56.00
57.00	05700	339,578	0	339,578	57.00
57.01	03630	362,320	0	362,320	57.01
58.00	05800	85,958	0	85,958	58.00
60.00	06000	3,773,645	0	3,773,645	60.00
65.00	06500	5,477,371	0	5,477,371	65.00
66.00	06600	4,933,097	0	4,933,097	66.00
69.00	06900	283,946	0	283,946	69.00
70.00	07000	722,199	0	722,199	70.00
71.00	07100	4,857,275	0	4,857,275	71.00
72.00	07200	969,909	0	969,909	72.00
73.00	07300	7,410,860	0	7,410,860	73.00
74.00	07400	1,088,174	0	1,088,174	74.00
76.00	03950	2,265,525	0	2,265,525	76.00
76.97	07697	0	0	0	76.97
76.98	07698	1,730,622	0	1,730,622	76.98
76.99	07699	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	380,856	0	380,856	90.00
90.02	09001	589,886	0	589,886	90.02
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		71,934,141	-2,873	71,931,268	118.00
NONREIMBURSABLE COST CENTERS					
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		71,934,141	-2,873	71,931,268	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part II
Date/Time Prepared:
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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			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,119	6,382	8,501	8,501 4.00
5.01 00540	NONPATIENT TELEPHONES	0	13,835	41,660	55,495	0 5.01
5.02 00550	DATA PROCESSING	0	0	0	0	0 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	37,447	112,762	150,209	0 5.03
5.04 00570	ADMITTING	0	0	0	0	0 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	43 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	0	438,367	1,320,057	1,758,424	1,094 5.06
6.00 00600	MAINTENANCE & REPAIRS	0	66,316	199,697	266,013	119 6.00
7.00 00700	OPERATION OF PLANT	0	252,319	759,807	1,012,126	100 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	29,455	88,697	118,152	0 8.00
9.00 00900	HOUSEKEEPING	0	20,843	62,763	83,606	248 9.00
10.00 01000	DIETARY	0	85,584	257,718	343,302	104 10.00
11.00 01100	CAFETERIA	0	0	0	0	68 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	166 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	41,486	124,927	166,413	25 14.00
15.00 01500	PHARMACY	0	34,203	102,995	137,198	279 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	22,201	66,854	89,055	95 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	1 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	198,872	598,861	797,733	3,017 30.00
31.00 03100	INTENSIVE CARE UNIT	0	22,810	68,687	91,497	428 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	166,267	500,679	666,946	297 50.00
53.00 05300	ANESTHESIOLOGY	0	656	1,975	2,631	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	44,338	133,513	177,851	129 54.00
56.00 05600	RADIOISOTOPE	0	7,699	23,184	30,883	10 56.00
57.00 05700	CT SCAN	0	3,033	9,132	12,165	37 57.00
57.01 03630	ULTRA SOUND	0	4,186	12,606	16,792	44 57.01
58.00 05800	MRI	0	0	0	0	10 58.00
60.00 06000	LABORATORY	0	38,214	115,072	153,286	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	3,115	9,379	12,494	818 65.00
66.00 06600	PHYSICAL THERAPY	0	66,363	199,838	266,201	641 66.00
69.00 06900	ELECTROCARDIOLOGY	0	10,533	31,717	42,250	17 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	17,915	53,948	71,863	60 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	1,914	5,765	7,679	161 74.00
76.00 03950	SUBSTANCE ABUSE	0	52,511	158,125	210,636	219 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	17,675	53,225	70,900	202 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	20,567	61,935	82,502	18 90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	0	16,686	50,246	66,932	51 90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,737,529	5,232,206	6,969,735	8,501 118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	1,737,529	5,232,206	6,969,735	8,501 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	55,495					5.01
5.02	00550	DATA PROCESSING	3,773	3,773				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,258	78	151,545			5.03
5.04	00570	ADMINING	0	0	0	0		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,818	342	292	0	3,495	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	9,811	1,143	6,350	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	755	47	2,357	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,057	16	1,817	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16	8,635	0	0	8.00
9.00	00900	HOUSEKEEPING	403	16	3,385	0	0	9.00
10.00	01000	DIETARY	352	16	14,364	0	0	10.00
11.00	01100	CAFETERIA	503	16	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	101	0	50	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	503	16	545	0	0	14.00
15.00	01500	PHARMACY	1,107	78	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,673	342	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,832	217	5,285	0	1,031	30.00
31.00	03100	INTENSIVE CARE UNIT	252	0	418	0	85	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,428	202	568	0	186	50.00
53.00	05300	ANESTHESIOLOGY	352	0	1	0	45	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,277	512	461	0	46	54.00
56.00	05600	RADIOISOTOPE	0	0	15	0	5	56.00
57.00	05700	CT SCAN	0	0	228	0	51	57.00
57.01	03630	ULTRA SOUND	0	0	8	0	30	57.01
58.00	05800	MRI	101	16	97	0	13	58.00
60.00	06000	LABORATORY	2,968	404	6,038	0	318	60.00
65.00	06500	RESPIRATORY THERAPY	1,208	78	1,971	0	488	65.00
66.00	06600	PHYSICAL THERAPY	1,107	155	114	0	119	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5	0	19	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	604	47	216	0	27	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	79,236	0	234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,503	0	16	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	631	73.00
74.00	07400	RENAL DIALYSIS	50	0	27	0	44	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	87	0	50	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	101	0	1,147	0	37	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	71	0	8	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	101	16	254	0	12	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,495	3,773	151,545	0	3,495	118.00
NONREIMBURSABLE COST CENTERS								
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)	55,495	3,773	151,545	0	3,495	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/19/2015 5:43 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.06	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.01	00540	NONPATIENT TELEPHONES				5.01		
5.02	00550	DATA PROCESSING				5.02		
5.03	00560	PURCHASING RECEIVING AND STORES				5.03		
5.04	00570	ADMITTING				5.04		
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05		
5.06	00590	ADMINISTRATIVE & GENERAL	1,776,822			5.06		
6.00	00600	MAINTENANCE & REPAIRS	34,233	303,524		6.00		
7.00	00700	OPERATION OF PLANT	135,188	64,933	1,215,237	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	13,816	7,580	38,608	186,807	8.00	
9.00	00900	HOUSEKEEPING	52,101	5,364	27,320	0	172,443	9.00
10.00	01000	DIETARY	49,869	22,025	112,180	0	16,832	10.00
11.00	01100	CAFETERIA	14,605	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	23,143	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,668	10,676	54,379	0	8,159	14.00
15.00	01500	PHARMACY	44,722	8,802	44,832	0	6,727	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,382	5,713	29,100	0	4,366	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	71	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	490,717	51,179	260,673	138,833	39,112	30.00
31.00	03100	INTENSIVE CARE UNIT	70,146	5,870	29,898	13,378	4,486	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,343	42,788	217,936	19,313	32,699	50.00
53.00	05300	ANESTHESIOLOGY	1,014	169	859	0	129	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,043	11,410	58,116	2,250	8,720	54.00
56.00	05600	RADIOISOTOPE	2,692	1,981	10,091	0	1,514	56.00
57.00	05700	CT SCAN	7,013	780	3,975	1,327	596	57.00
57.01	03630	ULTRA SOUND	7,416	1,077	5,487	1,538	823	57.01
58.00	05800	MRI	1,987	0	0	39	0	58.00
60.00	06000	LABORATORY	81,039	9,834	50,089	0	7,515	60.00
65.00	06500	RESPIRATORY THERAPY	128,490	802	4,083	163	613	65.00
66.00	06600	PHYSICAL THERAPY	102,788	17,078	86,986	4,540	13,051	66.00
69.00	06900	ELECTROCARDIOLOGY	4,121	2,711	13,806	170	2,071	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,671	4,610	23,483	221	3,523	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,182	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,584	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	25,110	493	2,509	0	377	74.00
76.00	03950	SUBSTANCE ABUSE	42,276	13,513	68,829	0	10,327	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	36,249	4,549	23,168	4,203	3,476	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,142	5,293	26,959	72	4,045	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	10,001	4,294	21,871	760	3,282	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,776,822	303,524	1,215,237	186,807	172,443	118.00
NONREIMBURSABLE COST CENTERS								
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)	1,776,822	303,524	1,215,237	186,807	172,443	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 142011		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/19/2015 5:43 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	559,044					10.00
11.00	01100	CAFETERIA	0	15,192				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	250	0	23,710		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	118	0	0	249,502	14.00
15.00	01500	PHARMACY	0	454	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	302	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	541,075	7,979	0	17,958	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,969	764	0	1,721	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	650	0	1,464	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	234	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	18	0	0	0	56.00
57.00	05700	CT SCAN	0	49	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	92	0	0	0	57.01
58.00	05800	MRI	0	19	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,866	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,258	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	37	0	83	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	155	0	350	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	207,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	42,501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	289	0	650	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	97	0	219	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	437	0	984	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	37	0	84	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	87	0	197	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	559,044	15,192	0	23,710	249,502	118.00
NONREIMBURSABLE COST CENTERS								
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)	559,044	15,192	0	23,710	249,502	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00540 NONPATIENT TELEPHONES						5.01
5.02 00550 DATA PROCESSING						5.02
5.03 00560 PURCHASING RECEIVING AND STORES						5.03
5.04 00570 ADMITTING						5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 00590 ADMINISTRATIVE & GENERAL						5.06
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	244,199					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	157,028				16.00
17.00 01700 SOCIAL SERVICE	0	0	0			17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	72		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	45,884	0			30.00
31.00 03100 INTENSIVE CARE UNIT	0	3,841	0			31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	8,386	0			50.00
53.00 05300 ANESTHESIOLOGY	0	2,013	0			53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	2,066	0			54.00
56.00 05600 RADIOISOTOPE	0	207	0			56.00
57.00 05700 CT SCAN	0	2,312	0			57.00
57.01 03630 ULTRA SOUND	0	1,334	0			57.01
58.00 05800 MRI	0	598	0			58.00
60.00 06000 LABORATORY	0	14,358	0			60.00
65.00 06500 RESPIRATORY THERAPY	0	22,044	0			65.00
66.00 06600 PHYSICAL THERAPY	0	5,368	0			66.00
69.00 06900 ELECTROCARDIOLOGY	0	848	0			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	1,224	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,568	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	706	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	244,199	28,501	0			73.00
74.00 07400 RENAL DIALYSIS	0	1,972	0			74.00
76.00 03950 SUBSTANCE ABUSE	0	2,252	0			76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0			76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	1,662	0			76.98
76.99 07699 LI THOTRI PSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	359	0			90.00
90.02 09001 WOMENS DIAGNOSTIC CENTER	0	525	0			90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	244,199	157,028	0	0	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments				72	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	244,199	157,028	0	72	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142011

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00540				5.01
5.02	00550				5.02
5.03	00560				5.03
5.04	00570				5.04
5.05	00580				5.05
5.06	00590				5.06
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
21.00	02100				21.00
22.00	02200				22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,414,525	0	2,414,525	30.00
31.00	03100	240,753	0	240,753	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,066,206	0	1,066,206	50.00
53.00	05300	7,213	0	7,213	53.00
54.00	05400	297,115	0	297,115	54.00
56.00	05600	47,416	0	47,416	56.00
57.00	05700	28,533	0	28,533	57.00
57.01	03630	34,641	0	34,641	57.01
58.00	05800	2,880	0	2,880	58.00
60.00	06000	325,849	0	325,849	60.00
65.00	06500	175,118	0	175,118	65.00
66.00	06600	499,406	0	499,406	66.00
69.00	06900	66,138	0	66,138	69.00
70.00	07000	119,054	0	119,054	70.00
71.00	07100	399,221	0	399,221	71.00
72.00	07200	81,310	0	81,310	72.00
73.00	07300	397,331	0	397,331	73.00
74.00	07400	39,361	0	39,361	74.00
76.00	03950	348,505	0	348,505	76.00
76.97	07697	0	0	0	76.97
76.98	07698	147,115	0	147,115	76.98
76.99	07699	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	123,590	0	123,590	90.00
90.02	09001	108,383	0	108,383	90.02
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		6,969,663	0	6,969,663	118.00
NONREIMBURSABLE COST CENTERS					
200.00		72	0	72	200.00
201.00		0	0	0	201.00
202.00		6,969,735	0	6,969,735	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142011

Period:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF LINES)	DATA PROCESSING (NUMBER OF INSTRUMENT)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	296,776				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		296,776			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	362	362	31,830,184		4.00
5.01	00540	NONPATIENT TELEPHONES	2,363	2,363		1,103	5.01
5.02	00550	DATA PROCESSING	0	0		75	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	6,396	6,396		25	5.03
5.04	00570	ADMINISTRATIVE	0	0		0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	161,692	56	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	74,875	74,875	4,096,339	195	5.06
6.00	00600	MAINTENANCE & REPAIRS	11,327	11,327	444,240	15	6.00
7.00	00700	OPERATION OF PLANT	43,097	43,097	375,200	21	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,031	5,031		0	8.00
9.00	00900	HOUSEKEEPING	3,560	3,560	927,337	8	9.00
10.00	01000	DIETARY	14,618	14,618	390,485	7	10.00
11.00	01100	CAFETERIA	0	0	253,487	10	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	622,148	2	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,086	7,086	92,276	10	14.00
15.00	01500	PHARMACY	5,842	5,842	1,046,323	22	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,792	3,792	355,914	73	16.00
17.00	01700	SOCIAL SERVICE	0	0		0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	2,298	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	33,968	33,968	11,296,113	275	30.00
31.00	03100	INTENSIVE CARE UNIT	3,896	3,896	1,601,844	5	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	28,399	28,399	1,110,779	88	50.00
53.00	05300	ANESTHESIOLOGY	112	112		7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,573	7,573	482,420	85	54.00
56.00	05600	RADIOISOTOPE	1,315	1,315	37,847	0	56.00
57.00	05700	CT SCAN	518	518	138,306	0	57.00
57.01	03630	ULTRA SOUND	715	715	166,526	0	57.01
58.00	05800	MRI	0	0	39,217	2	58.00
60.00	06000	LABORATORY	6,527	6,527		59	60.00
65.00	06500	RESPIRATORY THERAPY	532	532	3,064,197	24	65.00
66.00	06600	PHYSICAL THERAPY	11,335	11,335	2,401,014	22	66.00
69.00	06900	ELECTROCARDIOLOGY	1,799	1,799	65,198	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,060	3,060	225,649	12	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0	73.00
74.00	07400	RENAL DIALYSIS	327	327	602,140	1	74.00
76.00	03950	SUBSTANCE ABUSE	8,969	8,969	818,609	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0		0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,019	3,019	756,289	2	76.98
76.99	07699	LITHOTRIPSY	0	0		0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,513	3,513	66,657	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	2,850	2,850	189,640	2	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	296,776	296,776	31,830,184	1,103	243
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,737,529	5,232,206	108,676	256,918	1,267,361
203.00		Unit cost multiplier (Wkst. B, Part I)	5.854682	17.630152	0.003414	232.926564	5,215.477366
204.00		Cost to be allocated (per Wkst. B, Part II)			8,501	55,495	3,773
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000267	50.312783	15.526749

COST ALLOCATION - STATISTICAL BASIS

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Period:
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To 12/31/2014

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Cost Center Description			PURCHASING RECEIVING AND STORES (COST OF REQUISITIONS)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5,020,257					5.03
5.04	00570	ADMITTING	0	0				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	9,660	0	347,776,055			5.05
5.06	00590	ADMINISTRATIVE & GENERAL	210,344	0	0	-14,190,167	57,743,974	5.06
6.00	00600	MAINTENANCE & REPAIRS	78,069	0	0	0	1,112,508	6.00
7.00	00700	OPERATION OF PLANT	60,186	0	0	0	4,393,353	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	286,044	0	0	0	448,990	8.00
9.00	00900	HOUSEKEEPING	112,138	0	0	0	1,693,191	9.00
10.00	01000	DIETARY	475,826	0	0	0	1,620,634	10.00
11.00	01100	CAFETERIA	0	0	0	0	474,638	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,670	0	0	0	752,105	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,054	0	0	0	281,703	14.00
15.00	01500	PHARMACY	0	0	0	0	1,453,384	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	792,376	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	2,306	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	175,059	0	101,880,021	0	15,947,893	30.00
31.00	03100	INTENSIVE CARE UNIT	13,853	0	8,498,812	0	2,279,626	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,827	0	18,552,095	0	2,286,003	50.00
53.00	05300	ANESTHESIOLOGY	22	0	4,453,547	0	32,957	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,278	0	4,571,372	0	1,008,854	54.00
56.00	05600	RADIOISOTOPE	494	0	458,285	0	87,483	56.00
57.00	05700	CT SCAN	7,569	0	5,115,364	0	227,917	57.00
57.01	03630	ULTRA SOUND	264	0	2,952,242	0	240,994	57.01
58.00	05800	MRI	3,197	0	1,321,942	0	64,562	58.00
60.00	06000	LABORATORY	200,017	0	31,765,501	0	2,633,632	60.00
65.00	06500	RESPIRATORY THERAPY	65,292	0	48,770,340	0	4,175,695	65.00
66.00	06600	PHYSICAL THERAPY	3,772	0	11,876,182	0	3,340,427	66.00
69.00	06900	ELECTROCARDIOLOGY	174	0	1,876,495	0	133,914	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,169	0	2,708,325	0	411,790	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,624,968	0	23,379,797	0	3,320,730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	579,808	0	1,561,716	0	668,953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	63,056,286	0	4,029,774	73.00
74.00	07400	RENAL DIALYSIS	879	0	4,363,877	0	816,032	74.00
76.00	03950	SUBSTANCE ABUSE	2,866	0	4,982,666	0	1,373,885	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	37,998	0	3,676,997	0	1,178,032	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,348	0	793,773	0	134,622	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	8,412	0	1,160,420	0	325,011	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,020,257	0	347,776,055	-14,190,167	57,743,974	118.00
NONREIMBURSABLE COST CENTERS								
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)	694,635	0	1,986,231		14,190,167	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.138366	0.000000	0.005711		0.245743	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	151,545	0	3,495		1,776,822	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.030187	0.000000	0.000010		0.030771	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142011

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From 01/01/2014
To 12/31/2014

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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600	201,453					6.00
7.00	00700	43,097	158,356				7.00
8.00	00800	5,031	5,031	539,921			8.00
9.00	00900	3,560	3,560	0	149,765		9.00
10.00	01000	14,618	14,618	0	14,618	103,602	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	7,086	7,086	0	7,086	0	14.00
15.00	01500	5,842	5,842	0	5,842	0	15.00
16.00	01600	3,792	3,792	0	3,792	0	16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	33,968	33,968	401,266	33,968	100,272	30.00
31.00	03100	3,896	3,896	38,666	3,896	3,330	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	28,399	28,399	55,819	28,399	0	50.00
53.00	05300	112	112	0	112	0	53.00
54.00	05400	7,573	7,573	6,504	7,573	0	54.00
56.00	05600	1,315	1,315	0	1,315	0	56.00
57.00	05700	518	518	3,834	518	0	57.00
57.01	03630	715	715	4,446	715	0	57.01
58.00	05800	0	0	113	0	0	58.00
60.00	06000	6,527	6,527	0	6,527	0	60.00
65.00	06500	532	532	470	532	0	65.00
66.00	06600	11,335	11,335	13,122	11,335	0	66.00
69.00	06900	1,799	1,799	491	1,799	0	69.00
70.00	07000	3,060	3,060	638	3,060	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	327	327	0	327	0	74.00
76.00	03950	8,969	8,969	0	8,969	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	3,019	3,019	12,148	3,019	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,513	3,513	207	3,513	0	90.00
90.02	09001	2,850	2,850	2,197	2,850	0	90.02
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		201,453	158,356	539,921	149,765	103,602	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00		1,385,899	5,769,474	777,234	2,263,475	2,872,973	202.00
203.00		6.879515	36.433567	1.439533	15.113511	27.730864	203.00
204.00		303,524	1,215,237	186,807	172,443	559,044	204.00
205.00		1.506674	7.674082	0.345990	1.151424	5.396073	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1

Date/Time Prepared:
5/19/2015 5:43 pm

Cost Center Description		CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	42,250					11.00
12.00	01200	0	0				12.00
13.00	01300	695	0	29,292			13.00
14.00	01400	329	0	0	3,403,809		14.00
15.00	01500	1,262	0	0	0	3,669,660	15.00
16.00	01600	839	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	22,187	0	22,187	0	0	30.00
31.00	03100	2,126	0	2,126	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,809	0	1,809	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	651	0	0	0	0	54.00
56.00	05600	50	0	0	0	0	56.00
57.00	05700	137	0	0	0	0	57.00
57.01	03630	255	0	0	0	0	57.01
58.00	05800	52	0	0	0	0	58.00
60.00	06000	0	0	0	0	0	60.00
65.00	06500	5,190	0	0	0	0	65.00
66.00	06600	3,498	0	0	0	0	66.00
69.00	06900	102	0	102	0	0	69.00
70.00	07000	432	0	432	0	0	70.00
71.00	07100	0	0	0	2,824,001	0	71.00
72.00	07200	0	0	0	579,808	0	72.00
73.00	07300	0	0	0	0	3,669,660	73.00
74.00	07400	803	0	803	0	0	74.00
76.00	03950	270	0	270	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	1,216	0	1,216	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	104	0	104	0	0	90.00
90.02	09001	243	0	243	0	0	90.02
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		42,250	0	29,292	3,403,809	3,669,660	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00		591,277	0	946,656	769,544	2,169,532	202.00
203.00		13.994722	0.000000	32.317902	0.226083	0.591208	203.00
204.00		15,192	0	23,710	249,502	244,199	204.00
205.00		0.359574	0.000000	0.809436	0.073301	0.066545	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1

Date/Time Prepared:
5/19/2015 5:43 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00540	NONPATIENT TELEPHONES					5.01
5.02 00550	DATA PROCESSING					5.02
5.03 00560	PURCHASING RECEIVING AND STORES					5.03
5.04 00570	ADMINISTRATIVE					5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 00590	ADMINISTRATIVE & GENERAL					5.06
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	347,776,055				16.00
17.00 01700	SOCIAL SERVICE	0	0			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0		100		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	101,880,021	0	100	0	30.00
31.00 03100	INTENSIVE CARE UNIT	8,498,812	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	18,552,095	0	0	0	50.00
53.00 05300	ANESTHESIOLOGY	4,453,547	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,571,372	0	0	0	54.00
56.00 05600	RADIOISOTOPE	458,285	0	0	0	56.00
57.00 05700	CT SCAN	5,115,364	0	0	0	57.00
57.01 03630	ULTRA SOUND	2,952,242	0	0	0	57.01
58.00 05800	MRI	1,321,942	0	0	0	58.00
60.00 06000	LABORATORY	31,765,501	0	0	0	60.00
65.00 06500	RESPIRATORY THERAPY	48,770,340	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	11,876,182	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	1,876,495	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,708,325	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,379,797	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,561,716	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	63,056,286	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	4,363,877	0	0	0	74.00
76.00 03950	SUBSTANCE ABUSE	4,982,666	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	3,676,997	0	0	0	76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	793,773	0	0	0	90.00
90.02 09001	WOMENS DIAGNOSTIC CENTER	1,160,420	0	0	0	90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	347,776,055	0	100	0	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,220,392	0	2,873	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.003509	0.000000	28.730000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	157,028	0	72	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000452	0.000000	0.720000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet C
Part I
Date/Time Prepared:
5/19/2015 5:43 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	26,594,940		26,594,940	26,592	26,621,532	30.00
31.00	03100 INTENSIVE CARE UNIT	3,343,746		3,343,746	0	3,343,746	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,736,260		4,736,260	0	4,736,260	50.00
53.00	05300 ANESTHESIOLOGY	63,228		63,228	0	63,228	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,733,753		1,733,753	0	1,733,753	54.00
56.00	05600 RADIOISOTOPE	188,120		188,120	0	188,120	56.00
57.00	05700 CT SCAN	339,578		339,578	0	339,578	57.00
57.01	03630 ULTRA SOUND	362,320		362,320	0	362,320	57.01
58.00	05800 MRI	85,958		85,958	0	85,958	58.00
60.00	06000 LABORATORY	3,773,645		3,773,645	0	3,773,645	60.00
65.00	06500 RESPIRATORY THERAPY	5,477,371	0	5,477,371	0	5,477,371	65.00
66.00	06600 PHYSICAL THERAPY	4,933,097	0	4,933,097	0	4,933,097	66.00
69.00	06900 ELECTROCARDIOLOGY	283,946		283,946	0	283,946	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	722,199		722,199	0	722,199	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,857,275		4,857,275	0	4,857,275	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	969,909		969,909	0	969,909	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,410,860		7,410,860	0	7,410,860	73.00
74.00	07400 RENAL DIALYSIS	1,088,174		1,088,174	0	1,088,174	74.00
76.00	03950 SUBSTANCE ABUSE	2,265,525		2,265,525	0	2,265,525	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,730,622		1,730,622	0	1,730,622	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	380,856		380,856	0	380,856	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	589,886		589,886	0	589,886	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	71,931,268	0	71,931,268	26,592	71,957,860	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	71,931,268	0	71,931,268	26,592	71,957,860	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	101,880,021		101,880,021		30.00
31.00	03100	INTENSIVE CARE UNIT	8,498,812		8,498,812		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,752,724	16,799,371	18,552,095	0.255295	50.00
53.00	05300	ANESTHESIOLOGY	445,710	4,007,837	4,453,547	0.14197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,194,892	1,376,480	4,571,372	0.379263	54.00
56.00	05600	RADIOISOTOPE	68,548	389,737	458,285	0.410487	56.00
57.00	05700	CT SCAN	3,567,066	1,548,298	5,115,364	0.066384	57.00
57.01	03630	ULTRA SOUND	838,493	2,113,749	2,952,242	0.122727	57.01
58.00	05800	MRI	945	1,320,997	1,321,942	0.065024	58.00
60.00	06000	LABORATORY	25,437,390	6,328,111	31,765,501	0.118797	60.00
65.00	06500	RESPIRATORY THERAPY	48,730,254	40,086	48,770,340	0.112309	65.00
66.00	06600	PHYSICAL THERAPY	9,299,018	2,577,164	11,876,182	0.415377	66.00
69.00	06900	ELECTROCARDIOLOGY	986,737	889,758	1,876,495	0.151317	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,358	2,568,967	2,708,325	0.266659	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,733,040	1,646,757	23,379,797	0.207755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,946	1,341,770	1,561,716	0.621053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,712,075	4,344,211	63,056,286	0.117528	73.00
74.00	07400	RENAL DIALYSIS	4,363,877	0	4,363,877	0.249359	74.00
76.00	03950	SUBSTANCE ABUSE	0	4,982,666	4,982,666	0.454681	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	169,660	3,507,337	3,676,997	0.470662	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	12,527	781,246	793,773	0.479805	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,160,420	1,160,420	0.508338	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	290,051,093	57,724,962	347,776,055		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	290,051,093	57,724,962	347,776,055		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/19/2015 5:43 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.255295		50.00
53.00	05300 ANESTHESIOLOGY	0.014197		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.379263		54.00
56.00	05600 RADIOISOTOPE	0.410487		56.00
57.00	05700 CT SCAN	0.066384		57.00
57.01	03630 ULTRA SOUND	0.122727		57.01
58.00	05800 MRI	0.065024		58.00
60.00	06000 LABORATORY	0.118797		60.00
65.00	06500 RESPIRATORY THERAPY	0.112309		65.00
66.00	06600 PHYSICAL THERAPY	0.415377		66.00
69.00	06900 ELECTROCARDIOLOGY	0.151317		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266659		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.207755		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.621053		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117528		73.00
74.00	07400 RENAL DIALYSIS	0.249359		74.00
76.00	03950 SUBSTANCE ABUSE	0.454681		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.470662		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.479805		90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.508338		90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet C
Part I
Date/Time Prepared:
5/19/2015 5:43 pm

		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE			
				Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	26,594,940		26,594,940	26,592	26,621,532	30.00
31.00	03100 INTENSIVE CARE UNIT	3,343,746		3,343,746	0	3,343,746	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,736,260		4,736,260	0	4,736,260	50.00
53.00	05300 ANESTHESIOLOGY	63,228		63,228	0	63,228	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,733,753		1,733,753	0	1,733,753	54.00
56.00	05600 RADIOISOTOPE	188,120		188,120	0	188,120	56.00
57.00	05700 CT SCAN	339,578		339,578	0	339,578	57.00
57.01	03630 ULTRA SOUND	362,320		362,320	0	362,320	57.01
58.00	05800 MRI	85,958		85,958	0	85,958	58.00
60.00	06000 LABORATORY	3,773,645		3,773,645	0	3,773,645	60.00
65.00	06500 RESPIRATORY THERAPY	5,477,371	0	5,477,371	0	5,477,371	65.00
66.00	06600 PHYSICAL THERAPY	4,933,097	0	4,933,097	0	4,933,097	66.00
69.00	06900 ELECTROCARDIOLOGY	283,946		283,946	0	283,946	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	722,199		722,199	0	722,199	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,857,275		4,857,275	0	4,857,275	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	969,909		969,909	0	969,909	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,410,860		7,410,860	0	7,410,860	73.00
74.00	07400 RENAL DIALYSIS	1,088,174		1,088,174	0	1,088,174	74.00
76.00	03950 SUBSTANCE ABUSE	2,265,525		2,265,525	0	2,265,525	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,730,622		1,730,622	0	1,730,622	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	380,856		380,856	0	380,856	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	589,886		589,886	0	589,886	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	71,931,268	0	71,931,268	26,592	71,957,860	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	71,931,268	0	71,931,268	26,592	71,957,860	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet C
Part I
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5/19/2015 5:43 pm

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	101,880,021		101,880,021		30.00
31.00	03100	INTENSIVE CARE UNIT	8,498,812		8,498,812		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,752,724	16,799,371	18,552,095	0.255295	50.00
53.00	05300	ANESTHESIOLOGY	445,710	4,007,837	4,453,547	0.014197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,194,892	1,376,480	4,571,372	0.379263	54.00
56.00	05600	RADIOISOTOPE	68,548	389,737	458,285	0.410487	56.00
57.00	05700	CT SCAN	3,567,066	1,548,298	5,115,364	0.066384	57.00
57.01	03630	ULTRA SOUND	838,493	2,113,749	2,952,242	0.122727	57.01
58.00	05800	MRI	945	1,320,997	1,321,942	0.065024	58.00
60.00	06000	LABORATORY	25,437,390	6,328,111	31,765,501	0.118797	60.00
65.00	06500	RESPIRATORY THERAPY	48,730,254	40,086	48,770,340	0.112309	65.00
66.00	06600	PHYSICAL THERAPY	9,299,018	2,577,164	11,876,182	0.415377	66.00
69.00	06900	ELECTROCARDIOLOGY	986,737	889,758	1,876,495	0.151317	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,358	2,568,967	2,708,325	0.266659	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,733,040	1,646,757	23,379,797	0.207755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	219,946	1,341,770	1,561,716	0.621053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,712,075	4,344,211	63,056,286	0.117528	73.00
74.00	07400	RENAL DIALYSIS	4,363,877	0	4,363,877	0.249359	74.00
76.00	03950	SUBSTANCE ABUSE	0	4,982,666	4,982,666	0.454681	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	169,660	3,507,337	3,676,997	0.470662	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	12,527	781,246	793,773	0.479805	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,160,420	1,160,420	0.508338	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	290,051,093	57,724,962	347,776,055		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	290,051,093	57,724,962	347,776,055		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/19/2015 5:43 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.255295		50.00
53.00	05300 ANESTHESIOLOGY	0.014197		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.379263		54.00
56.00	05600 RADIOISOTOPE	0.410487		56.00
57.00	05700 CT SCAN	0.066384		57.00
57.01	03630 ULTRA SOUND	0.122727		57.01
58.00	05800 MRI	0.065024		58.00
60.00	06000 LABORATORY	0.118797		60.00
65.00	06500 RESPIRATORY THERAPY	0.112309		65.00
66.00	06600 PHYSICAL THERAPY	0.415377		66.00
69.00	06900 ELECTROCARDIOLOGY	0.151317		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266659		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.207755		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.621053		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117528		73.00
74.00	07400 RENAL DIALYSIS	0.249359		74.00
76.00	03950 SUBSTANCE ABUSE	0.454681		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.470662		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.479805		90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.508338		90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 142011

Period: From 01/01/2014 To 12/31/2014

Worksheet C Part II Date/Time Prepared: 5/19/2015 5:43 pm

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,736,260	1,066,206	3,670,054	0	0	50.00
53.00	05300	ANESTHESIOLOGY	63,228	7,213	56,015	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,733,753	297,115	1,436,638	0	0	54.00
56.00	05600	RADIOISOTOPE	188,120	47,416	140,704	0	0	56.00
57.00	05700	CT SCAN	339,578	28,533	311,045	0	0	57.00
57.01	03630	ULTRA SOUND	362,320	34,641	327,679	0	0	57.01
58.00	05800	MRI	85,958	2,880	83,078	0	0	58.00
60.00	06000	LABORATORY	3,773,645	325,849	3,447,796	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,477,371	175,118	5,302,253	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,933,097	499,406	4,433,691	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	283,946	66,138	217,808	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	722,199	119,054	603,145	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,857,275	399,221	4,458,054	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	969,909	81,310	888,599	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,410,860	397,331	7,013,529	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,088,174	39,361	1,048,813	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	2,265,525	348,505	1,917,020	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,730,622	147,115	1,583,507	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	380,856	123,590	257,266	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	589,886	108,383	481,503	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	41,992,582	4,314,385	37,678,197	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	41,992,582	4,314,385	37,678,197	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 142011

Period: From 01/01/2014 To 12/31/2014

Worksheet C Part II Date/Time Prepared: 5/19/2015 5:43 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	4,736,260	18,552,095	0.255295	50.00
53.00	05300 ANESTHESIOLOGY	63,228	4,453,547	0.014197	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,733,753	4,571,372	0.379263	54.00
56.00	05600 RADIOISOTOPE	188,120	458,285	0.410487	56.00
57.00	05700 CT SCAN	339,578	5,115,364	0.066384	57.00
57.01	03630 ULTRASOUND	362,320	2,952,242	0.122727	57.01
58.00	05800 MRI	85,958	1,321,942	0.065024	58.00
60.00	06000 LABORATORY	3,773,645	31,765,501	0.118797	60.00
65.00	06500 RESPIRATORY THERAPY	5,477,371	48,770,340	0.112309	65.00
66.00	06600 PHYSICAL THERAPY	4,933,097	11,876,182	0.415377	66.00
69.00	06900 ELECTROCARDIOLOGY	283,946	1,876,495	0.151317	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	722,199	2,708,325	0.266659	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4,857,275	23,379,797	0.207755	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	969,909	1,561,716	0.621053	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,410,860	63,056,286	0.117528	73.00
74.00	07400 RENAL DIALYSIS	1,088,174	4,363,877	0.249359	74.00
76.00	03950 SUBSTANCE ABUSE	2,265,525	4,982,666	0.454681	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,730,622	3,676,997	0.470662	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	380,856	793,773	0.479805	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	589,886	1,160,420	0.508338	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	41,992,582	237,397,222		200.00
201.00	Less Observation Beds	0	0		201.00
202.00	Total (line 200 minus line 201)	41,992,582	237,397,222		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142011		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/19/2015 5:43 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,414,525	0	2,414,525	33,424	72.24	30.00
31.00	INTENSIVE CARE UNIT	240,753		240,753	2,220	108.45	31.00
200.00	Total (Lines 30-199)	2,655,278		2,655,278	35,644		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	18,512	1,337,307				
31.00	INTENSIVE CARE UNIT	1,032	111,920				
200.00	Total (Lines 30-199)	19,544	1,449,227				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/19/2015 5:43 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,066,206	18,552,095	0.057471	989,309	56,857	50.00
53.00	05300	ANESTHESIOLOGY	7,213	4,453,547	0.001620	259,849	421	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,115	4,571,372	0.064995	1,817,152	118,106	54.00
56.00	05600	RADIOISOTOPE	47,416	458,285	0.103464	31,826	3,293	56.00
57.00	05700	CT SCAN	28,533	5,115,364	0.005578	1,892,070	10,554	57.00
57.01	03630	ULTRA SOUND	34,641	2,952,242	0.011734	486,702	5,711	57.01
58.00	05800	MRI	2,880	1,321,942	0.002179	0	0	58.00
60.00	06000	LABORATORY	325,849	31,765,501	0.010258	14,427,612	147,998	60.00
65.00	06500	RESPIRATORY THERAPY	175,118	48,770,340	0.003591	28,746,035	103,227	65.00
66.00	06600	PHYSICAL THERAPY	499,406	11,876,182	0.042051	5,407,460	227,389	66.00
69.00	06900	ELECTROCARDIOLOGY	66,138	1,876,495	0.035245	561,640	19,795	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	119,054	2,708,325	0.043959	74,626	3,280	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	399,221	23,379,797	0.017075	12,398,789	211,709	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,310	1,561,716	0.052065	112,458	5,855	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	397,331	63,056,286	0.006301	33,039,778	208,184	73.00
74.00	07400	RENAL DIALYSIS	39,361	4,363,877	0.009020	2,539,551	22,907	74.00
76.00	03950	SUBSTANCE ABUSE	348,505	4,982,666	0.069943	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	147,115	3,676,997	0.040010	126,586	5,065	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	123,590	793,773	0.155699	7,866	1,225	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	108,383	1,160,420	0.093400	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,314,385	237,397,222		102,919,309	1,151,576	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142011		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/19/2015 5:43 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			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
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	33,424	0.00	18,512	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,220	0.00	1,032	0	0	31.00
200.00		Total (lines 30-199)	35,644		19,544	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/19/2015 5:43 pm
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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	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	18,552,095	0.000000	0.000000	989,309	50.00
53.00	05300 ANESTHESIOLOGY	0	4,453,547	0.000000	0.000000	259,849	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,571,372	0.000000	0.000000	1,817,152	54.00
56.00	05600 RADIOISOTOPE	0	458,285	0.000000	0.000000	31,826	56.00
57.00	05700 CT SCAN	0	5,115,364	0.000000	0.000000	1,892,070	57.00
57.01	03630 ULTRASOUND	0	2,952,242	0.000000	0.000000	486,702	57.01
58.00	05800 MRI	0	1,321,942	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	31,765,501	0.000000	0.000000	14,427,612	60.00
65.00	06500 RESPIRATORY THERAPY	0	48,770,340	0.000000	0.000000	28,746,035	65.00
66.00	06600 PHYSICAL THERAPY	0	11,876,182	0.000000	0.000000	5,407,460	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,876,495	0.000000	0.000000	561,640	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,708,325	0.000000	0.000000	74,626	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,379,797	0.000000	0.000000	12,398,789	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,561,716	0.000000	0.000000	112,458	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	63,056,286	0.000000	0.000000	33,039,778	73.00
74.00	07400 RENAL DIALYSIS	0	4,363,877	0.000000	0.000000	2,539,551	74.00
76.00	03950 SUBSTANCE ABUSE	0	4,982,666	0.000000	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	3,676,997	0.000000	0.000000	126,586	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	793,773	0.000000	0.000000	7,866	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0	1,160,420	0.000000	0.000000	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	237,397,222			102,919,309	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/19/2015 5:43 pm
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	4,530,750	0	50.00
53.00	05300 ANESTHESIOLOGY	0	1,006,828	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	438,259	0	54.00
56.00	05600 RADIOISOTOPE	0	146,690	0	56.00
57.00	05700 CT SCAN	0	724,216	0	57.00
57.01	03630 ULTRASOUND	0	454,848	0	57.01
58.00	05800 MRI	0	312,363	0	58.00
60.00	06000 LABORATORY	0	829,210	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	34,777	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,135	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	266,905	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	564,369	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,501,314	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	27,289	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,437,410	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03950 SUBSTANCE ABUSE	0	18	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	1,430,876	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	211,064	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0	134,401	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00	Total (lines 50-199)	0	15,052,722	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/19/2015 5:43 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.255295	4,530,750	0	0	1,156,678	50.00
53.00	05300 ANESTHESIOLOGY	0.014197	1,006,828	0	0	14,294	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.379263	438,259	0	0	166,215	54.00
56.00	05600 RADIOISOTOPE	0.410487	146,690	0	0	60,214	56.00
57.00	05700 CT SCAN	0.066384	724,216	0	0	48,076	57.00
57.01	03630 ULTRASOUND	0.122727	454,848	0	0	55,822	57.01
58.00	05800 MRI	0.065024	312,363	0	0	20,311	58.00
60.00	06000 LABORATORY	0.118797	829,210	0	0	98,508	60.00
65.00	06500 RESPIRATORY THERAPY	0.112309	34,777	0	0	3,906	65.00
66.00	06600 PHYSICAL THERAPY	0.415377	1,135	0	0	471	66.00
69.00	06900 ELECTROCARDIOLOGY	0.151317	266,905	0	0	40,387	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266659	564,369	0	0	150,494	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.207755	1,501,314	0	1,915	311,905	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.621053	27,289	0	0	16,948	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117528	2,437,410	0	14,364	286,464	73.00
74.00	07400 RENAL DIALYSIS	0.249359	0	0	0	0	74.00
76.00	03950 SUBSTANCE ABUSE	0.454681	18	0	0	8	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.470662	1,430,876	0	0	673,459	76.98
76.99	07699 LI THOTRIPTY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.479805	211,064	0	0	101,270	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.508338	134,401	0	0	68,321	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Subtotal (see instructions)		15,052,722	0	16,279	3,273,751	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		15,052,722	0	16,279	3,273,751	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/19/2015 5:43 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
57.01	03630 ULTRASOUND	0	0	57.01
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	398	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,688	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 SUBSTANCE ABUSE	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	2,086	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	2,086	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142011		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/19/2015 5:43 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,414,525	0	2,414,525	33,424	72.24	
31.00	INTENSIVE CARE UNIT	240,753		240,753	2,220	108.45	
200.00	Total (Lines 30-199)	2,655,278		2,655,278	35,644	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	1,698	122,664	30.00			
31.00	INTENSIVE CARE UNIT	91	9,869	31.00			
200.00	Total (Lines 30-199)	1,789	132,533	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/19/2015 5:43 pm
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Cost Center Description		Title XIX			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								
50.00	05000	OPERATING ROOM	1,066,206	18,552,095	0.057471	56,263	3,233	50.00
53.00	05300	ANESTHESIOLOGY	7,213	4,453,547	0.001620	16,484	27	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,115	4,571,372	0.064995	153,926	10,004	54.00
56.00	05600	RADIOISOTOPE	47,416	458,285	0.103464	6,846	708	56.00
57.00	05700	CT SCAN	28,533	5,115,364	0.005578	161,114	899	57.00
57.01	03630	ULTRA SOUND	34,641	2,952,242	0.011734	45,517	534	57.01
58.00	05800	MRI	2,880	1,321,942	0.002179	0	0	58.00
60.00	06000	LABORATORY	325,849	31,765,501	0.010258	994,331	10,200	60.00
65.00	06500	RESPIRATORY THERAPY	175,118	48,770,340	0.003591	2,705,446	9,715	65.00
66.00	06600	PHYSICAL THERAPY	499,406	11,876,182	0.042051	417,286	17,547	66.00
69.00	06900	ELECTROCARDIOLOGY	66,138	1,876,495	0.035245	41,306	1,456	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	119,054	2,708,325	0.043959	10,700	470	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	399,221	23,379,797	0.017075	732,946	12,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	81,310	1,561,716	0.052065	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	397,331	63,056,286	0.006301	2,699,544	17,010	73.00
74.00	07400	RENAL DIALYSIS	39,361	4,363,877	0.009020	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	348,505	4,982,666	0.069943	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	147,115	3,676,997	0.040010	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	123,590	793,773	0.155699	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	108,383	1,160,420	0.093400	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,314,385	237,397,222		8,041,709	84,318	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142011		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/19/2015 5:43 pm	
Title XIX			Hospital			PPS		
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
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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	33,424	0.00	1,698	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,220	0.00	91	0		31.00
200.00		Total (lines 30-199)	35,644		1,789	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet D
Part IV
Date/Time Prepared:
5/19/2015 5:43 pm

Cost Center Description		Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/19/2015 5:43 pm
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Cost Center Description		Title XIX			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	18,552,095	0.000000	0.000000	56,263	50.00
53.00	05300	ANESTHESIOLOGY	0	4,453,547	0.000000	0.000000	16,484	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,571,372	0.000000	0.000000	153,926	54.00
56.00	05600	RADIOISOTOPE	0	458,285	0.000000	0.000000	6,846	56.00
57.00	05700	CT SCAN	0	5,115,364	0.000000	0.000000	161,114	57.00
57.01	03630	ULTRA SOUND	0	2,952,242	0.000000	0.000000	45,517	57.01
58.00	05800	MRI	0	1,321,942	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	31,765,501	0.000000	0.000000	994,331	60.00
65.00	06500	RESPIRATORY THERAPY	0	48,770,340	0.000000	0.000000	2,705,446	65.00
66.00	06600	PHYSICAL THERAPY	0	11,876,182	0.000000	0.000000	417,286	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,876,495	0.000000	0.000000	41,306	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,708,325	0.000000	0.000000	10,700	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,379,797	0.000000	0.000000	732,946	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,561,716	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	63,056,286	0.000000	0.000000	2,699,544	73.00
74.00	07400	RENAL DIALYSIS	0	4,363,877	0.000000	0.000000	0	74.00
76.00	03950	SUBSTANCE ABUSE	0	4,982,666	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,676,997	0.000000	0.000000	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	793,773	0.000000	0.000000	0	90.00
90.02	09001	WOMENS DIAGNOSTIC CENTER	0	1,160,420	0.000000	0.000000	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	237,397,222			8,041,709	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet D
Part IV
Date/Time Prepared:
5/19/2015 5:43 pm

Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
57.01	03630 ULTRA SOUND	0	0	0		57.01
58.00	05800 MRI	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03950 SUBSTANCE ABUSE	0	0	0		76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0	0	0		90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/19/2015 5:43 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		33,424	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		33,424	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)		33,424	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)		18,512	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		26,621,532	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)		26,621,532	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		26,621,532	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		796.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,744,438	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)		14,744,438	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/19/2015 5:43 pm
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	3,343,746	2,220	1,506.19	1,032	1,554,388 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)					15,662,712 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					31,961,538 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)					1,449,227 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,151,576 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,600,803 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					29,360,735 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: 142011		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/19/2015 5:43 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,414,525	26,621,532	0.090698	0	0	90.00
91.00	Nursing School cost	0	26,621,532	0.000000	0	0	91.00
92.00	Allied health cost	0	26,621,532	0.000000	0	0	92.00
93.00	All other Medical Education	0	26,621,532	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/19/2015 5:43 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		33,424	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		33,424	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)		33,424	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,698	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		26,621,532	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)		26,621,532	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		26,621,532	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		796.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,352,423	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,352,423	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/19/2015 5:43 pm					
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
Title XIX			Hospital		PPS					
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			3,343,746	2,220	1,506.19	91	137,063	43.00	
44.00	CORONARY CARE UNIT								44.00	
45.00	BURN INTENSIVE CARE UNIT								45.00	
46.00	SURGICAL INTENSIVE CARE UNIT								46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)								47.00	
Cost Center Description										
								1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							1,166,016	48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							2,655,502	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)							132,533	50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							84,318	51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)							216,851	52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							2,438,651	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: 142011		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/19/2015 5:43 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,414,525	26,621,532	0.090698	0	0	90.00
91.00	Nursing School cost	0	26,621,532	0.000000	0	0	91.00
92.00	Allied health cost	0	26,621,532	0.000000	0	0	92.00
93.00	All other Medical Education	0	26,621,532	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/19/2015 5:43 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		57,618,272		30.00
31.00	03100 INTENSIVE CARE UNIT		4,025,880		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.255295	989,309	252,566	50.00
53.00	05300 ANESTHESIOLOGY	0.014197	259,849	3,689	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.379263	1,817,152	689,179	54.00
56.00	05600 RADIOISOTOPE	0.410487	31,826	13,064	56.00
57.00	05700 CT SCAN	0.066384	1,892,070	125,603	57.00
57.01	03630 ULTRASOUND	0.122727	486,702	59,731	57.01
58.00	05800 MRI	0.065024	0	0	58.00
60.00	06000 LABORATORY	0.118797	14,427,612	1,713,957	60.00
65.00	06500 RESPIRATORY THERAPY	0.112309	28,746,035	3,228,438	65.00
66.00	06600 PHYSICAL THERAPY	0.415377	5,407,460	2,246,135	66.00
69.00	06900 ELECTROCARDIOLOGY	0.151317	561,640	84,986	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266659	74,626	19,900	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.207755	12,398,789	2,575,910	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.621053	112,458	69,842	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117528	33,039,778	3,883,099	73.00
74.00	07400 RENAL DIALYSIS	0.249359	2,539,551	633,260	74.00
76.00	03950 SUBSTANCE ABUSE	0.454681	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.470662	126,586	59,579	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.479805	7,866	3,774	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.508338	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		102,919,309	15,662,712	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)		102,919,309		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/19/2015 5:43 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		4,450,425		30.00
31.00	03100 INTENSIVE CARE UNIT		384,735		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.255295	56,263	14,364	50.00
53.00	05300 ANESTHESIOLOGY	0.014197	16,484	234	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.379263	153,926	58,378	54.00
56.00	05600 RADIOISOTOPE	0.410487	6,846	2,810	56.00
57.00	05700 CT SCAN	0.066384	161,114	10,695	57.00
57.01	03630 ULTRA SOUND	0.122727	45,517	5,586	57.01
58.00	05800 MRI	0.065024	0	0	58.00
60.00	06000 LABORATORY	0.118797	994,331	118,124	60.00
65.00	06500 RESPIRATORY THERAPY	0.112309	2,705,446	303,846	65.00
66.00	06600 PHYSICAL THERAPY	0.415377	417,286	173,331	66.00
69.00	06900 ELECTROCARDIOLOGY	0.151317	41,306	6,250	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.266659	10,700	2,853	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.207755	732,946	152,273	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.621053	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.117528	2,699,544	317,272	73.00
74.00	07400 RENAL DIALYSIS	0.249359	0	0	74.00
76.00	03950 SUBSTANCE ABUSE	0.454681	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.470662	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.479805	0	0	90.00
90.02	09001 WOMENS DIAGNOSTIC CENTER	0.508338	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		8,041,709	1,166,016	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)		8,041,709		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/19/2015 5:43 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,086	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,273,751	2.00
3.00	PPS payments		2,208,828	3.00
4.00	Outlier payment (see instructions)		18,875	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,086	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		16,279	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		16,279	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		16,279	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		14,193	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		2,086	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		2,227,703	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		531,267	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		1,698,522	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		202	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,698,724	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,698,724	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		127,539	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		82,900	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		121,224	36.00
37.00	Subtotal (see instructions)		1,781,624	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,781,624	40.00
40.01	Sequestration adjustment (see instructions)		35,632	40.01
41.00	Interim payments		1,663,380	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		82,612	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet E-1
Part I
Date/Time Prepared:
5/19/2015 5:43 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		29,528,101		1,663,380	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		29,528,101		1,663,380	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		512,928		82,612	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		30,041,029		1,745,992	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet E-1
Part II
Date/Time Prepared:
5/19/2015 5:43 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,481	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	19,544	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	30	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	35,644	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	347,776,055	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	0	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part IV Date/Time Prepared: 5/19/2015 5:43 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		26,932,061	1.00
2.00	Outlier Payments		6,082,613	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		33,014,674	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		33,014,674	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8)		33,014,674	9.00
10.00	Deductibles		47,424	10.00
11.00	Subtotal (line 9 minus line 10)		32,967,250	11.00
12.00	Coinsurance		2,836,488	12.00
13.00	Subtotal (line 11 minus line 12)		30,130,762	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		802,127	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		521,383	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		769,012	16.00
17.00	Subtotal (sum of lines 13 and 15)		30,652,145	17.00
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		1,966	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		30,654,111	22.00
22.01	Sequestration adjustment (see instructions)		613,082	22.01
23.00	Interim payments		29,528,101	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)		512,928	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)		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 (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/19/2015 5:43 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		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)		0	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)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		4,835,160		8.00
9.00	Ancillary service charges		8,041,709	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)		12,876,869	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		12,876,869	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		12,876,869	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)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/19/2015 5:43 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			2.57	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.19	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-1.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.38	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.09	6.00
7.00	Enter the lesser of line 5 or line 6			0.09	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.08	0.00	0.08	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.08	0.00	0.08	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	0.08	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.03	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.02	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.04	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	0.04	0.00		17.00
18.00	Per resident amount	98,702.00	0.00		18.00
19.00	Approved amount for resident costs	3,948	0	3,948	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			3,948	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	19,544	30		26.00
27.00	Total Inpatient Days (see instructions)	35,644	35,644		27.00
28.00	Ratio of inpatient days to total inpatient days	0.548311	0.000842		28.00
29.00	Program direct GME amount	2,165	3		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		0		30.00
31.00	Net Program direct GME amount			2,168	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 142011	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/19/2015 5:43 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		4,363,877	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		31,961,538	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		31,961,538	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		3,275,837	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		3,275,837	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		35,237,375	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.907035	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.092965	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		2,168	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		1,966	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		202	50.00

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

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet G

Date/Time Prepared:
5/19/2015 5:43 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	8,087	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	21,781,974	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	41,142	0	0	0	6.00
7.00	Inventory	1,013,107	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	36,240	0	0	0	9.00
10.00	Due from other funds	428,106	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,308,656	0	0	0	11.00
FIXED ASSETS						
12.00	Land	342,000	0	0	0	12.00
13.00	Land improvements	4,077,827	0	0	0	13.00
14.00	Accumulated depreciation	-4,009,038	0	0	0	14.00
15.00	Buildings	85,557,685	0	0	0	15.00
16.00	Accumulated depreciation	-70,667,875	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	2,119,028	0	0	0	19.00
20.00	Accumulated depreciation	-2,013,891	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	35,971,471	0	0	0	23.00
24.00	Accumulated depreciation	-29,549,481	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)	21,827,726	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	293,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	293,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	45,429,382	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	-191,225	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	47,417,789	0	0	0	43.00
44.00	Other current liabilities	10,254,755	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	57,481,319	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,169,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,169,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	60,650,319	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-15,220,937	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-15,220,937	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	45,429,382	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet G-1

Date/Time Prepared:
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		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		-18,268,120		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,047,180				2.00
3.00	Total (sum of line 1 and line 2)		-15,220,940		0		3.00
4.00	RECONCILING ITEM	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		-15,220,937		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)		-15,220,937		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	RECONCILING ITEM		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: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/19/2015 5:43 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	109,031,090		109,031,090	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)	109,031,090		109,031,090	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	9,536,791		9,536,791	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)	9,536,791		9,536,791	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	118,567,881		118,567,881	17.00
18.00	Ancillary services	171,467,923	55,520,506	226,988,429	18.00
19.00	Outpatient services	0	2,202,939	2,202,939	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	CLINIC OP REVENUE	0	16,804	16,804	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	290,035,804	57,740,249	347,776,053	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		72,987,644		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		72,987,644		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142011

Period:
From 01/01/2014
To 12/31/2014

Worksheet G-3

Date/Time Prepared:
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	347,776,053	1.00
2.00	Less contractual allowances and discounts on patients' accounts	273,126,579	2.00
3.00	Net patient revenues (line 1 minus line 2)	74,649,474	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	72,987,644	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,661,830	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,422	6.00
7.00	Income from investments	13,621	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	348,541	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	780	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	INTERCOMPANY RENTAL	858,156	24.00
24.01	NET ASSETS RELEASED	725	24.01
24.02	OTHER REVENUE	161,105	24.02
25.00	Total other income (sum of lines 6-24)	1,385,350	25.00
26.00	Total (line 5 plus line 25)	3,047,180	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)	3,047,180	29.00