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: 140007	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/21/2015 9:31 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/21/2015 Time: 9:31 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE ST. JOSEPH MEDICAL CENTER (140007) 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	1,989,241	59,985	-29,988	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	126,249	-29		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	2,115,490	59,956	-29,988	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2015 9:30 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 333 NORTH MADISON STREET	PO Box:			1.00
2.00	City: JOLIET	State: IL	Zip Code: 60435	County: CHAMPAIGN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PRESENCE ST. JOSEPH MEDICAL CENTER	140007	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	SJMC PHYSICAL MED & REHAB	14T007	16974	5	09/07/1987	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 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.	Y	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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	12,037	5,809	0	0	713	1,686	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	220	351	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 9:30 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	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)	Y			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 9:30 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 9:30 am

		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.	Y			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)	N	N	0	76.00

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

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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	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	1,154,138	6,407,450	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	148003	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: 00450	141.00
142.00	Street: 200 SOUTH WACKER DRIVE	PO Box:		142.00
143.00	City: CHICAGO	State: IL	Zip Code: 60606	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	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.	Y		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
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)	0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140007	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 9:30 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2015 9:30 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/30/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		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.	Y		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	05/01/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/21/2015 9:30 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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.	815/806-2327	SANDRA.COSLER@PRESENCEHEALTH.ORG			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2015 9:30 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/01/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SYSTEM DIRECTOR 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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/21/2015 9:30 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	367	133,955	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)		367	133,955	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	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	34.00	18	6,570	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		415	151,475	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	31	11,315		0	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)		446				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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2015 9:30 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	40,458	15,153	79,717			1.00
2.00	HMO and other (see instructions)	7,877	713				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	597	46				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)	40,458	15,153	79,717			7.00
8.00	INTENSIVE CARE UNIT	3,333	1,122	8,139			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	2,946	650	6,539			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		2,607	4,048			13.00
14.00	Total (see instructions)	46,737	19,532	98,443	1.00	1,917.13	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	8,561	305	11,289	0.00	13.50	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)				1.00	1,930.63	27.00
28.00	Observation Bed Days		1,593	10,749			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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/21/2015 9:30 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	9,616	4,644	21,735	1.00
2.00	HMO and other (see instructions)			1,586	196		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	9,616	4,644	21,735	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	691	23	906	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2015 9:30 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	127,806,205	-98,657	127,707,548	4,015,697.00	31.80	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	76,811	76,811	2,080.00	36.93	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		7,108,798	299,105	7,407,903	189,533.00	39.09	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		8,351,653	76,811	8,428,464	212,614.00	39.64	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,214,269	0	1,214,269	10,837.00	112.05	13.00
14.00	Home office salaries & wage-related costs		22,863,080	0	22,863,080	512,657.00	44.60	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		25,840,991	0	25,840,991			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,280,060	0	1,280,060			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	98,657	-98,657	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	10,548,576	0	10,548,576	363,775.00	29.00	27.00
28.00	Administrative & General under contract (see inst.)		367,979	0	367,979	4,625.00	79.56	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,854,613	0	2,854,613	108,260.00	26.37	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	2,466,354	0	2,466,354	181,359.00	13.60	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,593,416	-1,491,214	1,102,202	78,660.00	14.01	34.00
35.00	Dietary under contract (see instructions)		1,252,891	0	1,252,891	29,382.00	42.64	35.00
36.00	Cafeteria	11.00	0	1,491,214	1,491,214	106,446.00	14.01	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	5,607,048	0	5,607,048	133,637.00	41.96	38.00
39.00	Central Services and Supply	14.00	885,476	0	885,476	48,633.00	18.21	39.00
40.00	Pharmacy	15.00	3,900,284	-299,105	3,601,179	88,390.00	40.74	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2015 9:30 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	2,948,836	0	2,948,836	125,999.00	23.40	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/21/2015 9:30 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		129,427,075	-175,468	129,251,607	4,047,624.00	31.93	1.00
2.00	Excluded area salaries (see instructions)		7,108,798	299,105	7,407,903	189,533.00	39.09	2.00
3.00	Subtotal salaries (line 1 minus line 2)		122,318,277	-474,573	121,843,704	3,858,091.00	31.58	3.00
4.00	Subtotal other wages & related costs (see inst.)		32,429,002	76,811	32,505,813	736,108.00	44.16	4.00
5.00	Subtotal wage-related costs (see inst.)		25,840,991	0	25,840,991	0.00	21.21	5.00
6.00	Total (sum of lines 3 thru 5)		180,588,270	-397,762	180,190,508	4,594,199.00	39.22	6.00
7.00	Total overhead cost (see instructions)		33,524,130	-397,762	33,126,368	1,269,166.00	26.10	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/21/2015 9:30 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	2,039,423	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	524,859	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	12,442,863	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	288,626	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	66,232	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	644,414	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,523,105	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	9,081,388	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	222,273	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	287,868	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	27,121,051	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 5/21/2015 9:30 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	8,351,653	0	1.00
2.00	Hospital	8,351,653	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/21/2015 9:30 am

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

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/21/2015 9:30 am

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

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

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/21/2015 9:30 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.176550	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	41,001,141	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	325,271,641	6.00
7.00	Medicaid cost (line 1 times line 6)	57,426,708	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	16,425,567	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	16,425,567	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	49,551,072	3,927,128	53,478,200	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	8,748,242	693,334	9,441,576	21.00
22.00	Partial payment by patients approved for charity care	364,635	693,334	1,057,969	22.00
23.00	Cost of charity care (line 21 minus line 22)	8,383,607	0	8,383,607	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	17,941,341	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	1,103,840	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	16,837,501	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,972,661	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	11,356,268	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	27,781,835	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		23,297,682	23,297,682	3,486,197	26,783,879	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	6,786,988	6,786,988	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	98,657	27,144,631	27,243,288	-101,738	27,141,550	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,548,576	69,630,660	80,179,236	-273,179	79,906,057	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,854,613	10,881,812	13,736,425	-4,652	13,731,773	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	982,957	982,957	0	982,957	8.00
9.00	00900	HOUSEKEEPING	2,466,354	1,352,312	3,818,666	-804	3,817,862	9.00
10.00	01000	DIETARY	2,593,416	3,622,300	6,215,716	-3,538,654	2,677,062	10.00
11.00	01100	CAFETERIA	0	0	0	3,521,065	3,521,065	11.00
13.00	01300	NURSING ADMINISTRATION	5,607,048	299,540	5,906,588	-683	5,905,905	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	885,476	1,986,594	2,872,070	-1,222,546	1,649,524	14.00
15.00	01500	PHARMACY	3,900,284	16,442,256	20,342,540	-914,990	19,427,550	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,948,836	1,300,629	4,249,465	-34	4,249,431	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	76,811	76,811	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	329,320	20,938	350,258	299,105	649,363	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,604,342	4,351,214	40,955,556	-6,972,238	33,983,318	30.00
31.00	03100	INTENSIVE CARE UNIT	6,311,731	495,341	6,807,072	-373,211	6,433,861	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,200,455	390,120	4,590,575	-350,145	4,240,430	34.00
41.00	04100	SUBPROVIDER - IRF	3,195,028	200,873	3,395,901	-92,868	3,303,033	41.00
43.00	04300	NURSERY	1,316,704	61,433	1,378,137	-42,103	1,336,034	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,853,861	31,395,893	41,249,754	-23,974,090	17,275,664	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,109,455	6,353,239	15,462,694	-3,261,624	12,201,070	54.00
60.00	06000	LABORATORY	0	13,910,197	13,910,197	-173,293	13,736,904	60.00
65.00	06500	RESPIRATORY THERAPY	2,320,248	582,653	2,902,901	-278,336	2,624,565	65.00
66.00	06600	PHYSICAL THERAPY	7,254,122	2,526,072	9,780,194	-288,430	9,491,764	66.00
69.00	06900	ELECTROCARDIOLOGY	3,274,391	7,961,769	11,236,160	-7,853,352	3,382,808	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	340,276	25,811	366,087	-18,821	347,266	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	16,213,262	16,213,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,488,644	24,488,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	462,663	114,778	577,441	5,490,152	6,067,593	76.00
76.10	03550	OUTPATIENT PSYCH	337,104	17,825	354,929	-388	354,541	76.10
76.97	07697	CARDIAC REHABILITATION	498,204	4,806	503,010	-1,886	501,124	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,910,591	1,880,360	8,790,951	-592,513	8,198,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		9,956,371	9,956,371	-9,956,371	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	124,221,755	237,191,066	361,412,821	75,275	361,488,096	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	3,584,450	9,408,230	12,992,680	-75,275	12,917,405	192.01
200.00		TOTAL (SUM OF LINES 118-199)	127,806,205	246,599,296	374,405,501	0	374,405,501	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/21/2015 9:30 am

		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	-2,534,129	24,249,750		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-170,927	6,616,061		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-468	27,141,082		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,580,755	73,325,302		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-82,366	13,649,407		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	982,957		8.00
9.00	00900	HOUSEKEEPING	0	3,817,862		9.00
10.00	01000	DIETARY	-1,801,412	875,650		10.00
11.00	01100	CAFETERIA	0	3,521,065		11.00
13.00	01300	NURSING ADMINISTRATION	-38,897	5,867,008		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,649,524		14.00
15.00	01500	PHARMACY	-176,840	19,250,710		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,103	4,243,328		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	76,811		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	649,363		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,586,792	32,396,526		30.00
31.00	03100	INTENSIVE CARE UNIT	-32,431	6,401,430		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	4,240,430		34.00
41.00	04100	SUBPROVIDER - IRF	0	3,303,033		41.00
43.00	04300	NURSERY	0	1,336,034		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,156,605	15,119,059		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,096,147	11,104,923		54.00
60.00	06000	LABORATORY	-133,935	13,602,969		60.00
65.00	06500	RESPIRATORY THERAPY	-7,368	2,617,197		65.00
66.00	06600	PHYSICAL THERAPY	-29,024	9,462,740		66.00
69.00	06900	ELECTROCARDIOLOGY	-98,736	3,284,072		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	347,266		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,213,262		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,488,644		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	OTHER ANCILLARY	-14,283	6,053,310		76.00
76.10	03550	OUTPATIENT PSYCH	0	354,541		76.10
76.97	07697	CARDIAC REHABILITATION	-1,768	499,356		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-69,634	8,128,804		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-16,618,620	344,869,476		118.00
		NONREIMBURSABLE COST CENTERS				
192.01	19201	OTHER NRCC	0	12,917,405		192.01
200.00		TOTAL (SUM OF LINES 118-199)	-16,618,620	357,786,881		200.00

RECLASSIFICATIONS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/21/2015 9:30 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	1,491,214	2,029,851		1.00
	TOTALS		1,491,214	2,029,851		
	B - RECLASS CAPITAL INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	194,302		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	59,073		2.00
	TOTALS		0	253,375		
	C - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,956,371		1.00
	TOTALS		0	9,956,371		
	D - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16,213,262		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	24,488,644		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
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
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
	TOTALS		0	40,701,906		
	E - RECLASS MOVABLE EQ DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,727,915		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	63,439		2.00
	TOTALS		0	6,791,354		
	F - RECLASS IV THERAPY					
1.00	OTHER ANCILLARY	76.00	4,914,796	584,229		1.00
	TOTALS		4,914,796	584,229		
	G - RECLASS PHARMARCIST TEACHING					
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	299,105	0		1.00
	TOTALS		299,105	0		
	H - RECLASS RESIDENT COSTS					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	76,811		1.00
	TOTALS		0	76,811		
	I - RECLASS BENEFIT DOLLARS TO NONWAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	98,657		1.00
	TOTALS		0	98,657		
500.00	Grand Total: Increases		6,705,115	60,492,554		500.00

RECLASSIFICATIONS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/21/2015 9:30 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,491,214	2,029,851	0		1.00
	TOTALS		1,491,214	2,029,851			
	B - RECLASS CAPITAL INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	194,302	12		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	59,073	12		2.00
	TOTALS		0	253,375			
	C - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	9,956,371	11		1.00
	TOTALS		0	9,956,371			
	D - RECLASS MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,081	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	41,650	0		2.00
3.00	OPERATION OF PLANT	7.00	0	4,652	0		3.00
4.00	HOUSEKEEPING	9.00	0	804	0		4.00
5.00	DIETARY	10.00	0	17,589	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	683	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,222,546	0		7.00
8.00	PHARMACY	15.00	0	615,885	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	34	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	1,473,213	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	373,211	0		11.00
12.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	350,145	0		12.00
13.00	SUBPROVIDER - IRF	41.00	0	92,868	0		13.00
14.00	NURSERY	43.00	0	42,103	0		14.00
15.00	OPERATING ROOM	50.00	0	23,974,090	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,261,624	0		16.00
17.00	LABORATORY	60.00	0	173,293	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	278,336	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	288,430	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	7,853,352	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	18,821	0		21.00
22.00	OTHER ANCILLARY	76.00	0	8,873	0		22.00
23.00	OUTPATIENT PSYCH	76.10	0	388	0		23.00
24.00	CARDIAC REHABILITATION	76.97	0	1,886	0		24.00
25.00	EMERGENCY	91.00	0	592,513	0		25.00
26.00	OTHER NRCC	192.01	0	11,836	0		26.00
	TOTALS		0	40,701,906			
	E - RECLASS MOVABLE EQ DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,727,915	9		1.00
2.00	OTHER NRCC	192.01	0	63,439	9		2.00
	TOTALS		0	6,791,354			
	F - RECLASS IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	4,914,796	584,229	0		1.00
	TOTALS		4,914,796	584,229			
	G - RECLASS PHARMARCIST TEACHING						
1.00	PHARMACY	15.00	299,105	0	0		1.00
	TOTALS		299,105	0			
	H - RECLASS RESIDENT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	76,811	0		1.00
	TOTALS		0	76,811			
	I - RECLASS BENEFIT DOLLARS TO NONWAGE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	98,657	0	0		1.00
	TOTALS		98,657	0			
500.00	Grand Total: Decreases		6,803,772	60,393,897			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/21/2015 9:30 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,884,595	0	0	0	0	1.00
2.00	Land Improvements	3,208,539	82,133	0	82,133	1,333,182	2.00
3.00	Buildings and Fixtures	331,941,605	2,670,827	0	2,670,827	918,998	3.00
4.00	Building Improvements	1,439,521	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	128,563,049	7,985,620	0	7,985,620	9,379,102	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	467,037,309	10,738,580	0	10,738,580	11,631,282	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	467,037,309	10,738,580	0	10,738,580	11,631,282	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,884,595	0	1.00
2.00	Land Improvements	1,957,490	0	2.00
3.00	Buildings and Fixtures	333,693,434	0	3.00
4.00	Building Improvements	1,439,521	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	127,169,567	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	466,144,607	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	466,144,607	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/21/2015 9:30 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	23,297,682	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)	23,297,682	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	23,297,682	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	23,297,682	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/21/2015 9:30 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	337,535,519	0	337,535,519	0.724100	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	128,609,088	0	128,609,088	0.275900	0	2.00
3.00	Total (sum of lines 1-2)	466,144,607	0	466,144,607	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	14,099,077	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,556,988	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,656,065	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	9,956,371	194,302	0	0	24,249,750	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	59,073	0	0	6,616,061	2.00
3.00	Total (sum of lines 1-2)	9,956,371	253,375	0	0	30,865,811	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/21/2015 9:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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	-6,090,119			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	-7,253,665			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	MISC INCOME	B	-468	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
34.00	MISC INCOME	B	-581,912	ADMINISTRATIVE & GENERAL	5.00	0	34.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/21/2015 9:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	MISC INCOME	B	-82,366	OPERATION OF PLANT	7.00	0	35.00
36.00	MISC INCOME	B	-1,801,412	DIETARY	10.00	0	36.00
37.00	MISC INCOME	B	-3,334	NURSING ADMINISTRATION	13.00	0	37.00
38.00	MISC INCOME	B	-152,113	PHARMACY	15.00	0	38.00
39.00	MISC INCOME	B	-6,103	MEDICAL RECORDS & LIBRARY	16.00	0	39.00
40.00	MISC INCOME	B	-32,108	ADULTS & PEDIATRICS	30.00	0	40.00
41.00	MISC INCOME	B	-28	OPERATING ROOM	50.00	0	41.00
42.00	MISC INCOME	B	-14,773	RADIOLOGY-DIAGNOSTIC	54.00	0	42.00
43.00	MISC INCOME	B	-24,768	LABORATORY	60.00	0	43.00
44.00	MISC INCOME	B	-29,024	PHYSICAL THERAPY	66.00	0	44.00
44.01	MISC INCOME	B	-8,860	ELECTROCARDIOLOGY	69.00	0	44.01
44.02	MISC INCOME	B	-1,768	CARDIAC REHABILITATION	76.97	0	44.02
44.03	MISC INCOME	B	-385	EMERGENCY	91.00	0	44.03
45.00	NONALLOWABLE EXP	A	-269	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	MARKETING OFFSET	A	-279,676	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.01	NRCC DEPR EXPENSE	A	-63,439	CAP REL COSTS-MVBLE EQUIP	2.00	9	47.01
48.00	PATIENT TRANSPORTATION	A	-192,030	ADMINISTRATIVE & GENERAL	5.00	0	48.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,618,620				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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/21/2015 9:30 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	7,374,210	9,908,339	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION	5,159,267	5,266,755	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATION	26,220,207	48,850,271	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	IT	12,083,547	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	CBO	4,397,234	0	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	EICU	905,448	0	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	ESICU	610,619	0	3.04
4.00	60.00	LABORATORY	ALVERNO LAB	11,256,722	11,235,554	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			68,007,254	75,260,919	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140007	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/21/2015 9:30 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-2,534,129	9		1.00
2.00	-107,488	9		2.00
3.00	-22,630,064	0		3.00
3.01	12,083,547	0		3.01
3.02	4,397,234	0		3.02
3.03	905,448	0		3.03
3.04	610,619	0		3.04
4.00	21,168	0		4.00
5.00	-7,253,665			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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/21/2015 9:30 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,008,662	831,255	177,407	177,200	1,350	1.00
2.00	13.00	NURSING ADMINISTRATION	35,563	35,563	0	0	0	2.00
3.00	15.00	PHARMACY	27,027	20,356	6,671	177,200	27	3.00
4.00	30.00	ADULTS & PEDIATRICS	1,941,627	1,463,844	477,783	177,200	4,542	4.00
5.00	31.00	INTENSIVE CARE UNIT	56,029	680	55,349	177,200	277	5.00
6.00	41.00	SUBPROVIDER - IRF	64,167	0	64,167	177,200	880	6.00
7.00	50.00	OPERATING ROOM	2,156,577	2,156,577	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	1,081,374	1,081,374	0	0	0	8.00
9.00	60.00	LABORATORY	130,335	130,335	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	32,500	3,000	29,500	177,200	295	10.00
11.00	69.00	ELECTROCARDIOLOGY	166,625	3,864	162,761	165,600	964	11.00
12.00	76.00	OTHER ANCILLARY	15,000	14,150	850	165,600	9	12.00
13.00	91.00	EMERGENCY	309,030	69,249	239,781	208,000	2,493	13.00
200.00			7,024,516	5,810,247	1,214,269		10,837	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	115,010	5,751	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	15.00	PHARMACY	2,300	115	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	386,943	19,347	0	0	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	23,598	1,180	0	0	0	5.00
6.00	41.00	SUBPROVIDER - IRF	74,969	3,748	0	0	0	6.00
7.00	50.00	OPERATING ROOM	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	25,132	1,257	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	76,749	3,837	0	0	0	11.00
12.00	76.00	OTHER ANCILLARY	717	36	0	0	0	12.00
13.00	91.00	EMERGENCY	249,300	12,465	0	0	0	13.00
200.00			954,718	47,736	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	115,010	62,397	893,652		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	35,563		2.00
3.00	15.00	PHARMACY	0	2,300	4,371	24,727		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	386,943	90,840	1,554,684		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	23,598	31,751	32,431		5.00
6.00	41.00	SUBPROVIDER - IRF	0	74,969	0	0		6.00
7.00	50.00	OPERATING ROOM	0	0	0	2,156,577		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,081,374		8.00
9.00	60.00	LABORATORY	0	0	0	130,335		9.00
10.00	65.00	RESPIRATORY THERAPY	0	25,132	4,368	7,368		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	76,749	86,012	89,876		11.00
12.00	76.00	OTHER ANCILLARY	0	717	133	14,283		12.00
13.00	91.00	EMERGENCY	0	249,300	0	69,249		13.00
200.00			0	954,718	279,872	6,090,119		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	24,249,750	24,249,750				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,616,061		6,616,061			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	27,141,082	100,413	3,466	27,244,961		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	73,325,302	6,008,525	1,335,504	2,250,423	82,919,754	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	13,649,407	3,547,664	2,391,228	609,000	20,197,299	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	982,957	141,296	391	0	1,124,644	8.00
9.00	00900	HOUSEKEEPING	3,817,862	265,942	41,879	526,169	4,651,852	9.00
10.00	01000	DIETARY	875,650	217,232	38,952	235,143	1,366,977	10.00
11.00	01100	CAFETERIA	3,521,065	295,607	18,889	318,134	4,153,695	11.00
13.00	01300	NURSING ADMINISTRATION	5,867,008	127,839	57,342	1,196,202	7,248,391	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,649,524	511,376	62,725	188,907	2,412,532	14.00
15.00	01500	PHARMACY	19,250,710	69,484	7,778	768,272	20,096,244	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,243,328	235,479	9,541	629,102	5,117,450	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	76,811	0	0	0	76,811	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	649,363	5,321	70	134,068	788,822	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,396,526	5,911,258	304,080	6,760,577	45,372,441	30.00
31.00	03100	INTENSIVE CARE UNIT	6,401,430	607,067	77,781	1,346,538	8,432,816	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,240,430	481,689	52,011	896,121	5,670,251	34.00
41.00	04100	SUBPROVIDER - IRF	3,303,033	379,015	9,410	681,624	4,373,082	41.00
43.00	04300	NURSERY	1,336,034	180,473	11,890	280,904	1,809,301	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,119,059	1,776,481	673,725	2,102,213	19,671,478	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,104,923	950,497	746,275	1,943,402	14,745,097	54.00
60.00	06000	LABORATORY	13,602,969	285,675	10,684	0	13,899,328	60.00
65.00	06500	RESPIRATORY THERAPY	2,617,197	48,732	22,047	494,999	3,182,975	65.00
66.00	06600	PHYSICAL THERAPY	9,462,740	183,133	51,574	1,547,587	11,245,034	66.00
69.00	06900	ELECTROCARDIOLOGY	3,284,072	381,764	275,519	698,555	4,639,910	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	347,266	100,236	13,642	72,594	533,738	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,213,262	0	0	0	16,213,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,488,644	0	0	0	24,488,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	6,053,310	93,052	2,182	1,147,222	7,295,766	76.00
76.10	03550	OUTPATIENT PSYCH	354,541	7,006	1,516	71,917	434,980	76.10
76.97	07697	CARDIAC REHABILITATION	499,356	131,231	2,720	106,286	739,593	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,128,804	701,139	98,506	1,474,299	10,402,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	344,869,476	23,744,626	6,321,327	26,480,258	343,304,915	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	12,917,405	505,124	294,734	764,703	14,481,966	192.01
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)	357,786,881	24,249,750	6,616,061	27,244,961	357,786,881	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	82,919,754					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	6,092,960	0	26,290,259			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	339,274	0	254,552	1,718,470		8.00
9.00	00900	HOUSEKEEPING	1,403,333	0	479,108	0	6,534,293	9.00
10.00	01000	DIETARY	412,379	0	391,355	0	100,061	10.00
11.00	01100	CAFETERIA	1,253,053	0	532,551	0	136,162	11.00
13.00	01300	NURSING ADMINISTRATION	2,186,637	0	230,307	0	58,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	727,793	0	921,269	0	235,549	14.00
15.00	01500	PHARMACY	6,062,474	0	125,179	0	32,006	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,543,791	0	424,227	0	108,466	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	23,172	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	237,966	0	9,586	0	2,451	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,687,635	0	10,649,418	1,248,416	2,722,834	30.00
31.00	03100	INTENSIVE CARE UNIT	2,543,944	0	1,093,660	127,462	279,626	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,710,556	0	867,786	102,405	221,875	34.00
41.00	04100	SUBPROVIDER - IRF	1,319,236	0	682,814	176,793	174,581	41.00
43.00	04300	NURSERY	545,815	0	325,130	63,394	83,129	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,934,334	0	3,200,416	0	818,280	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,448,183	0	1,712,366	0	437,817	54.00
60.00	06000	LABORATORY	4,193,038	0	514,656	0	131,587	60.00
65.00	06500	RESPIRATORY THERAPY	960,214	0	87,793	0	22,447	65.00
66.00	06600	PHYSICAL THERAPY	3,392,312	0	329,923	0	84,355	66.00
69.00	06900	ELECTROCARDIOLOGY	1,399,731	0	687,766	0	175,848	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	161,014	0	180,579	0	46,170	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,891,087	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,387,538	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	2,200,928	0	167,638	0	42,862	76.00
76.10	03550	OUTPATIENT PSYCH	131,221	0	12,622	0	3,227	76.10
76.97	07697	CARDIAC REHABILITATION	223,114	0	236,418	0	60,447	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,138,218	0	1,263,135	0	322,958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	78,550,950	0	25,380,254	1,718,470	6,301,623	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	4,368,804	0	910,005	0	232,670	192.01
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)	82,919,754	0	26,290,259	1,718,470	6,534,293	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,270,772					10.00
11.00	01100	CAFETERIA	0	6,075,461				11.00
13.00	01300	NURSING ADMINISTRATION	0	255,546	9,979,766			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	92,991	0	4,390,134		14.00
15.00	01500	PHARMACY	0	169,038	0	0	26,484,941	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	240,949	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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	40,967	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,693,350	1,915,576	4,866,901	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	174,876	303,672	771,538	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	140,498	233,909	594,291	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	242,561	202,686	514,965	0	0	41.00
43.00	04300	NURSERY	0	53,694	136,421	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	467,499	1,187,774	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	504,886	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	149,907	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	354,821	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	169,356	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,830	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,748,779	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,641,355	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	26,484,941	73.00
76.00	03950	OTHER ANCILLARY	0	318,865	810,140	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	20,205	51,335	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	27,484	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	19,487	411,856	1,046,401	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,270,772	5,956,737	9,979,766	4,390,134	26,484,941	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	118,724	0	0	0	192.01
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)	2,270,772	6,075,461	9,979,766	4,390,134	26,484,941	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	
			16.00	17.00	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,434,883					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	99,983		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	1,079,792	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	757,281	0	0	49,991	0	30.00
31.00	03100	INTENSIVE CARE UNIT	167,582	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	121,049	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	79,577	0	0	0	0	41.00
43.00	04300	NURSERY	35,060	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	659,427	0	0	49,992	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,419,871	0	0	0	0	54.00
60.00	06000	LABORATORY	981,195	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	159,110	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	238,157	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	469,283	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,541	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	548,512	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	407,482	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	621,629	0	0	0	1,079,792	73.00
76.00	03950	OTHER ANCILLARY	141,814	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	5,110	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	8,418	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	593,785	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,434,883	0	0	99,983	1,079,792	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,434,883	0	0	99,983	1,079,792	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	82,963,843	-49,991	82,913,852		30.00
31.00	03100	INTENSIVE CARE UNIT	13,895,176	0	13,895,176		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,662,620	0	9,662,620		34.00
41.00	04100	SUBPROVIDER - IRF	7,766,295	0	7,766,295		41.00
43.00	04300	NURSERY	3,051,944	0	3,051,944		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	31,989,200	-49,992	31,939,208		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,268,220	0	23,268,220		54.00
60.00	06000	LABORATORY	19,719,804	0	19,719,804		60.00
65.00	06500	RESPIRATORY THERAPY	4,562,446	0	4,562,446		65.00
66.00	06600	PHYSICAL THERAPY	15,644,602	0	15,644,602		66.00
69.00	06900	ELECTROCARDIOLOGY	7,541,894	0	7,541,894		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	964,872	0	964,872		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,401,640	0	23,401,640		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,925,019	0	34,925,019		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,186,362	0	28,186,362		73.00
76.00	03950	OTHER ANCILLARY	10,978,013	0	10,978,013		76.00
76.10	03550	OUTPATIENT PSYCH	658,700	0	658,700		76.10
76.97	07697	CARDIAC REHABILITATION	1,295,474	0	1,295,474		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	17,198,588	0	17,198,588		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	337,674,712	-99,983	337,574,729		118.00
		NONREIMBURSABLE COST CENTERS					
192.01	19201	OTHER NRCC	20,112,169	0	20,112,169		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	357,786,881	-99,983	357,686,898		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	100,413	3,466	103,879	103,879	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	6,008,525	1,335,504	7,344,029	8,576	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	3,547,664	2,391,228	5,938,892	2,321	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	141,296	391	141,687	0	8.00
9.00	00900	HOUSEKEEPING	0	265,942	41,879	307,821	2,005	9.00
10.00	01000	DIETARY	0	217,232	38,952	256,184	896	10.00
11.00	01100	CAFETERIA	0	295,607	18,889	314,496	1,212	11.00
13.00	01300	NURSING ADMINISTRATION	0	127,839	57,342	185,181	4,559	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	511,376	62,725	574,101	720	14.00
15.00	01500	PHARMACY	0	69,484	7,778	77,262	2,928	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	235,479	9,541	245,020	2,397	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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	5,321	70	5,391	511	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,911,258	304,080	6,215,338	25,817	30.00
31.00	03100	INTENSIVE CARE UNIT	0	607,067	77,781	684,848	5,131	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	481,689	52,011	533,700	3,415	34.00
41.00	04100	SUBPROVIDER - IRF	0	379,015	9,410	388,425	2,598	41.00
43.00	04300	NURSERY	0	180,473	11,890	192,363	1,070	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,776,481	673,725	2,450,206	8,011	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	950,497	746,275	1,696,772	7,406	54.00
60.00	06000	LABORATORY	0	285,675	10,684	296,359	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	48,732	22,047	70,779	1,886	65.00
66.00	06600	PHYSICAL THERAPY	0	183,133	51,574	234,707	5,898	66.00
69.00	06900	ELECTROCARDIOLOGY	0	381,764	275,519	657,283	2,662	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	100,236	13,642	113,878	277	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
76.00	03950	OTHER ANCILLARY	0	93,052	2,182	95,234	4,372	76.00
76.10	03550	OUTPATIENT PSYCH	0	7,006	1,516	8,522	274	76.10
76.97	07697	CARDIAC REHABILITATION	0	131,231	2,720	133,951	405	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	701,139	98,506	799,645	5,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	23,744,626	6,321,327	30,065,953	100,965	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	505,124	294,734	799,858	2,914	192.01
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	24,249,750	6,616,061	30,865,811	103,879	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,352,605					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	540,278	0	6,481,491			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,084	0	62,756	234,527		8.00
9.00	00900	HOUSEKEEPING	124,437	0	118,117	0	552,380	9.00
10.00	01000	DIETARY	36,567	0	96,483	0	8,459	10.00
11.00	01100	CAFETERIA	111,111	0	131,293	0	11,511	11.00
13.00	01300	NURSING ADMINISTRATION	193,894	0	56,779	0	4,978	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,535	0	227,126	0	19,912	14.00
15.00	01500	PHARMACY	537,575	0	30,861	0	2,706	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	136,892	0	104,587	0	9,169	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	2,055	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	21,101	0	2,363	0	207	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,213,620	0	2,625,464	170,376	230,177	30.00
31.00	03100	INTENSIVE CARE UNIT	225,578	0	269,626	17,395	23,638	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	151,679	0	213,940	13,976	18,756	34.00
41.00	04100	SUBPROVIDER - IRF	116,980	0	168,338	24,128	14,758	41.00
43.00	04300	NURSERY	48,399	0	80,156	8,652	7,027	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	526,212	0	789,017	0	69,174	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	394,431	0	422,160	0	37,011	54.00
60.00	06000	LABORATORY	371,807	0	126,881	0	11,124	60.00
65.00	06500	RESPIRATORY THERAPY	85,145	0	21,644	0	1,898	65.00
66.00	06600	PHYSICAL THERAPY	300,805	0	81,338	0	7,131	66.00
69.00	06900	ELECTROCARDIOLOGY	124,118	0	169,559	0	14,865	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,277	0	44,519	0	3,903	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	433,705	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	655,071	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	195,162	0	41,329	0	3,623	76.00
76.10	03550	OUTPATIENT PSYCH	11,636	0	3,112	0	273	76.10
76.97	07697	CARDIAC REHABILITATION	19,784	0	58,286	0	5,110	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	278,274	0	311,408	0	27,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,965,212	0	6,257,142	234,527	532,711	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	387,393	0	224,349	0	19,669	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,352,605	0	6,481,491	234,527	552,380	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	398,589					10.00
11.00	01100	CAFETERIA	0	569,623				11.00
13.00	01300	NURSING ADMINISTRATION	0	23,959	469,350			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,719	0	895,113		14.00
15.00	01500	PHARMACY	0	15,849	0	0	667,181	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,591	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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	3,841	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	297,233	179,601	228,891	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	30,696	28,472	36,286	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	24,662	21,931	27,950	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	42,577	19,003	24,219	0	0	41.00
43.00	04300	NURSERY	0	5,034	6,416	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,832	55,861	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,337	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,055	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	33,267	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,878	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,141	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	356,562	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	538,551	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	667,181	73.00
76.00	03950	OTHER ANCILLARY	0	29,896	38,101	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,894	2,414	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	2,577	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,421	38,615	49,212	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	398,589	558,492	469,350	895,113	667,181	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	11,131	0	0	0	192.01
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)	398,589	569,623	469,350	895,113	667,181	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	
			16.00	17.00	21.00	22.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520,656					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		2,055		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			33,414	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,978	0				30.00
31.00	03100	INTENSIVE CARE UNIT	11,724	0				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,468	0				34.00
41.00	04100	SUBPROVIDER - IRF	5,567	0				41.00
43.00	04300	NURSERY	2,453	0				43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,133	0				50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,855	0				54.00
60.00	06000	LABORATORY	68,643	0				60.00
65.00	06500	RESPIRATORY THERAPY	11,131	0				65.00
66.00	06600	PHYSICAL THERAPY	16,661	0				66.00
69.00	06900	ELECTROCARDIOLOGY	32,831	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,437	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,373	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,507	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,488	0				73.00
76.00	03950	OTHER ANCILLARY	9,921	0				76.00
76.10	03550	OUTPATIENT PSYCH	357	0				76.10
76.97	07697	CARDIAC REHABILITATION	589	0				76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	41,540	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	520,656	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	0				192.01
200.00		Cross Foot Adjustments			0	2,055	33,414	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	520,656	0	0	2,055	33,414	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,239,495	0	11,239,495		30.00
31.00	03100	INTENSIVE CARE UNIT	1,333,394	0	1,333,394		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,018,477	0	1,018,477		34.00
41.00	04100	SUBPROVIDER - IRF	806,593	0	806,593		41.00
43.00	04300	NURSERY	351,570	0	351,570		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,988,446	0	3,988,446		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,704,972	0	2,704,972		54.00
60.00	06000	LABORATORY	874,814	0	874,814		60.00
65.00	06500	RESPIRATORY THERAPY	206,538	0	206,538		65.00
66.00	06600	PHYSICAL THERAPY	679,807	0	679,807		66.00
69.00	06900	ELECTROCARDIOLOGY	1,017,196	0	1,017,196		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	180,432	0	180,432		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	828,640	0	828,640		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,222,129	0	1,222,129		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	710,669	0	710,669		73.00
76.00	03950	OTHER ANCILLARY	417,638	0	417,638		76.00
76.10	03550	OUTPATIENT PSYCH	28,482	0	28,482		76.10
76.97	07697	CARDIAC REHABILITATION	220,702	0	220,702		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	1,555,034	0	1,555,034		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,385,028	0	29,385,028		118.00
		NONREIMBURSABLE COST CENTERS					
192.01	19201	OTHER NRCC	1,445,314	0	1,445,314		192.01
200.00		Cross Foot Adjustments	35,469	0	35,469		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	30,865,811	0	30,865,811		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,093,755					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		16,510,560				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,529	8,650	127,707,548			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	271,007	3,332,786	10,548,576	-82,919,754	274,867,127	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	160,013	5,967,374	2,854,613	0	20,197,299	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,373	975	0	0	1,124,644	8.00
9.00	00900	HOUSEKEEPING	11,995	104,509	2,466,354	0	4,651,852	9.00
10.00	01000	DIETARY	9,798	97,207	1,102,202	0	1,366,977	10.00
11.00	01100	CAFETERIA	13,333	47,138	1,491,214	0	4,153,695	11.00
13.00	01300	NURSING ADMINISTRATION	5,766	143,099	5,607,048	0	7,248,391	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,065	156,533	885,476	0	2,412,532	14.00
15.00	01500	PHARMACY	3,134	19,410	3,601,179	0	20,096,244	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,621	23,811	2,948,836	0	5,117,450	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	76,811	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	240	175	628,425	0	788,822	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	266,620	758,841	31,689,546	0	45,372,441	30.00
31.00	03100	INTENSIVE CARE UNIT	27,381	194,105	6,311,731	0	8,432,816	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	21,726	129,796	4,200,455	0	5,670,251	34.00
41.00	04100	SUBPROVIDER - IRF	17,095	23,482	3,195,028	0	4,373,082	41.00
43.00	04300	NURSERY	8,140	29,671	1,316,704	0	1,809,301	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,126	1,681,298	9,853,861	0	19,671,478	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,871	1,862,349	9,109,455	0	14,745,097	54.00
60.00	06000	LABORATORY	12,885	26,661	0	0	13,899,328	60.00
65.00	06500	RESPIRATORY THERAPY	2,198	55,019	2,320,248	0	3,182,975	65.00
66.00	06600	PHYSICAL THERAPY	8,260	128,705	7,254,122	0	11,245,034	66.00
69.00	06900	ELECTROCARDIOLOGY	17,219	687,566	3,274,391	0	4,639,910	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,521	34,044	340,276	0	533,738	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	16,213,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	24,488,644	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY	4,197	5,445	5,377,459	0	7,295,766	76.00
76.10	03550	OUTPATIENT PSYCH	316	3,782	337,104	0	434,980	76.10
76.97	07697	CARDIAC REHABILITATION	5,919	6,787	498,204	0	739,593	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	31,624	245,825	6,910,591	0	10,402,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,070,972	15,775,043	124,123,098	-82,919,754	260,385,161	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	22,783	735,517	3,584,450	0	14,481,966	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	24,249,750	6,616,061	27,244,961		82,919,754	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.171099	0.400717	0.213339		0.301672	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			103,879		7,352,605	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000813		0.026750	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	658,206				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,373	109,732			8.00
9.00	00900	HOUSEKEEPING	0	11,995	0	639,838		9.00
10.00	01000	DIETARY	0	9,798	0	9,798	434,765	10.00
11.00	01100	CAFETERIA	0	13,333	0	13,333	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,766	0	5,766	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,065	0	23,065	0	14.00
15.00	01500	PHARMACY	0	3,134	0	3,134	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,621	0	10,621	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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	240	0	240	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	266,620	79,717	266,620	324,211	30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,381	8,139	27,381	33,482	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	21,726	6,539	21,726	26,900	34.00
41.00	04100	SUBPROVIDER - IRF	0	17,095	11,289	17,095	46,441	41.00
43.00	04300	NURSERY	0	8,140	4,048	8,140	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	80,126	0	80,126	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,871	0	42,871	0	54.00
60.00	06000	LABORATORY	0	12,885	0	12,885	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,198	0	2,198	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,260	0	8,260	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,219	0	17,219	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,521	0	4,521	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
76.00	03950	OTHER ANCILLARY	0	4,197	0	4,197	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	316	0	316	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	5,919	0	5,919	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	31,624	0	31,624	3,731	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	635,423	109,732	617,055	434,765	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	22,783	0	22,783	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	26,290,259	1,718,470	6,534,293	2,270,772	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	39.942296	15.660609	10.212418	5.222987	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	6,481,491	234,527	552,380	398,589	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	9.847207	2.137271	0.863312	0.916792	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	152,751					11.00
13.00	01300	NURSING ADMINISTRATION	6,425	98,758				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,338	0	40,701,906			14.00
15.00	01500	PHARMACY	4,250	0	0	13,702,449		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,058	0	0	0	1,912,060,830	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
23.00	02300	PARAMED ED PRGM-(SPECIFY)	1,030	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,162	48,162	0	0	194,773,886	30.00
31.00	03100	INTENSIVE CARE UNIT	7,635	7,635	0	0	43,102,356	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,881	5,881	0	0	31,133,976	34.00
41.00	04100	SUBPROVIDER - IRF	5,096	5,096	0	0	20,467,294	41.00
43.00	04300	NURSERY	1,350	1,350	0	0	9,017,545	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,754	11,754	0	0	169,605,601	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,694	0	0	0	364,989,458	54.00
60.00	06000	LABORATORY	0	0	0	0	252,365,088	60.00
65.00	06500	RESPIRATORY THERAPY	3,769	0	0	0	40,923,359	65.00
66.00	06600	PHYSICAL THERAPY	8,921	0	0	0	61,254,487	66.00
69.00	06900	ELECTROCARDIOLOGY	4,258	0	0	0	120,700,458	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	574	0	0	0	5,283,185	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16,213,262	0	141,078,308	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,488,644	0	104,805,148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,702,449	159,883,985	73.00
76.00	03950	OTHER ANCILLARY	8,017	8,017	0	0	36,474,796	76.00
76.10	03550	OUTPATIENT PSYCH	508	508	0	0	1,314,333	76.10
76.97	07697	CARDIAC REHABILITATION	691	0	0	0	2,165,181	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,355	10,355	0	0	152,722,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	149,766	98,758	40,701,906	13,702,449	1,912,060,830	118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	2,985	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,075,461	9,979,766	4,390,134	26,484,941	7,434,883	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.773625	101.052735	0.107861	1.932862	0.003888	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	569,623	469,350	895,113	667,181	520,656	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.729095	4.752526	0.021992	0.048691	0.000272	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 9:30 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			17.00	21.00	22.00	23.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		100			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0			100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	50	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0		34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100		73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	100	100		118.00
		NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	0	0	0	0		192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	99,983	1,079,792		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	999.830000	10,797.920000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	2,055	33,414		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	20.550000	334.140000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 9:30 am

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	82,913,852		82,913,852	90,840	83,004,692	30.00
31.00	03100	INTENSIVE CARE UNIT	13,895,176		13,895,176	31,751	13,926,927	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,662,620		9,662,620	0	9,662,620	34.00
41.00	04100	SUBPROVIDER - IRF	7,766,295		7,766,295	0	7,766,295	41.00
43.00	04300	NURSERY	3,051,944		3,051,944	0	3,051,944	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,939,208		31,939,208	0	31,939,208	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,268,220		23,268,220	0	23,268,220	54.00
60.00	06000	LABORATORY	19,719,804		19,719,804	0	19,719,804	60.00
65.00	06500	RESPIRATORY THERAPY	4,562,446	0	4,562,446	4,368	4,566,814	65.00
66.00	06600	PHYSICAL THERAPY	15,644,602	0	15,644,602	0	15,644,602	66.00
69.00	06900	ELECTROCARDIOLOGY	7,541,894		7,541,894	86,012	7,627,906	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	964,872		964,872	0	964,872	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,401,640		23,401,640	0	23,401,640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,925,019		34,925,019	0	34,925,019	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,186,362		28,186,362	0	28,186,362	73.00
76.00	03950	OTHER ANCILLARY	10,978,013		10,978,013	133	10,978,146	76.00
76.10	03550	OUTPATIENT PSYCH	658,700		658,700	0	658,700	76.10
76.97	07697	CARDIAC REHABILITATION	1,295,474		1,295,474	0	1,295,474	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,198,588		17,198,588	0	17,198,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,862,422		9,862,422		9,862,422	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	347,437,151	0	347,437,151	213,104	347,650,255	200.00
201.00		Less Observation Beds	9,862,422		9,862,422		9,862,422	201.00
202.00		Total (see instructions)	337,574,729	0	337,574,729	213,104	337,787,833	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	171,110,559		171,110,559			30.00
31.00	03100	INTENSIVE CARE UNIT	43,102,356		43,102,356			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	31,133,976		31,133,976			34.00
41.00	04100	SUBPROVIDER - IRF	20,467,294		20,467,294			41.00
43.00	04300	NURSERY	9,017,545		9,017,545			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,253,954	94,351,647	169,605,601	0.188315	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,306,281	240,683,177	364,989,458	0.063750	0.000000	54.00
60.00	06000	LABORATORY	128,254,546	124,110,542	252,365,088	0.078140	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	36,874,190	4,049,169	40,923,359	0.111488	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	32,004,658	29,249,829	61,254,487	0.255403	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	53,590,723	67,109,735	120,700,458	0.062484	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,593,475	3,689,710	5,283,185	0.182631	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	90,909,094	50,169,214	141,078,308	0.165877	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,577,805	34,227,343	104,805,148	0.333238	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,215,184	34,668,801	159,883,985	0.176293	0.000000	73.00
76.00	03950	OTHER ANCILLARY	3,902,146	32,572,650	36,474,796	0.300975	0.000000	76.00
76.10	03550	OUTPATIENT PSYCH	795,923	518,410	1,314,333	0.501167	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	8,297	2,156,884	2,165,181	0.598321	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	51,792,227	100,930,159	152,722,386	0.112613	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,684,590	16,978,737	23,663,327	0.416781	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,076,594,823	835,466,007	1,912,060,830			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,076,594,823	835,466,007	1,912,060,830			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.188315	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.063750	54.00
60.00	06000	LABORATORY	0.078140	60.00
65.00	06500	RESPIRATORY THERAPY	0.111594	65.00
66.00	06600	PHYSICAL THERAPY	0.255403	66.00
69.00	06900	ELECTROCARDIOLOGY	0.063197	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.182631	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.165877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.333238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176293	73.00
76.00	03950	OTHER ANCILLARY	0.300979	76.00
76.10	03550	OUTPATIENT PSYCH	0.501167	76.10
76.97	07697	CARDIAC REHABILITATION	0.598321	76.97
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.112613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416781	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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,913,852		82,913,852	90,840	83,004,692	30.00
31.00	03100	INTENSIVE CARE UNIT	13,895,176		13,895,176	31,751	13,926,927	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,662,620		9,662,620	0	9,662,620	34.00
41.00	04100	SUBPROVIDER - IRF	7,766,295		7,766,295	0	7,766,295	41.00
43.00	04300	NURSERY	3,051,944		3,051,944	0	3,051,944	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,939,208		31,939,208	0	31,939,208	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,268,220		23,268,220	0	23,268,220	54.00
60.00	06000	LABORATORY	19,719,804		19,719,804	0	19,719,804	60.00
65.00	06500	RESPIRATORY THERAPY	4,562,446	0	4,562,446	4,368	4,566,814	65.00
66.00	06600	PHYSICAL THERAPY	15,644,602	0	15,644,602	0	15,644,602	66.00
69.00	06900	ELECTROCARDIOLOGY	7,541,894		7,541,894	86,012	7,627,906	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	964,872		964,872	0	964,872	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,401,640		23,401,640	0	23,401,640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,925,019		34,925,019	0	34,925,019	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,186,362		28,186,362	0	28,186,362	73.00
76.00	03950	OTHER ANCILLARY	10,978,013		10,978,013	133	10,978,146	76.00
76.10	03550	OUTPATIENT PSYCH	658,700		658,700	0	658,700	76.10
76.97	07697	CARDIAC REHABILITATION	1,295,474		1,295,474	0	1,295,474	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,198,588		17,198,588	0	17,198,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,862,422		9,862,422		9,862,422	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	347,437,151	0	347,437,151	213,104	347,650,255	200.00
201.00		Less Observation Beds	9,862,422		9,862,422		9,862,422	201.00
202.00		Total (see instructions)	337,574,729	0	337,574,729	213,104	337,787,833	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	171,110,559		171,110,559			30.00
31.00	03100	INTENSIVE CARE UNIT	43,102,356		43,102,356			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	31,133,976		31,133,976			34.00
41.00	04100	SUBPROVIDER - IRF	20,467,294		20,467,294			41.00
43.00	04300	NURSERY	9,017,545		9,017,545			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,253,954	94,351,647	169,605,601	0.188315	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,306,281	240,683,177	364,989,458	0.063750	0.000000	54.00
60.00	06000	LABORATORY	128,254,546	124,110,542	252,365,088	0.078140	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	36,874,190	4,049,169	40,923,359	0.111488	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	32,004,658	29,249,829	61,254,487	0.255403	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	53,590,723	67,109,735	120,700,458	0.062484	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,593,475	3,689,710	5,283,185	0.182631	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	90,909,094	50,169,214	141,078,308	0.165877	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	70,577,805	34,227,343	104,805,148	0.333238	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,215,184	34,668,801	159,883,985	0.176293	0.000000	73.00
76.00	03950	OTHER ANCILLARY	3,902,146	32,572,650	36,474,796	0.300975	0.000000	76.00
76.10	03550	OUTPATIENT PSYCH	795,923	518,410	1,314,333	0.501167	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	8,297	2,156,884	2,165,181	0.598321	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	51,792,227	100,930,159	152,722,386	0.112613	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,684,590	16,978,737	23,663,327	0.416781	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,076,594,823	835,466,007	1,912,060,830			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,076,594,823	835,466,007	1,912,060,830			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY	0.000000		76.00
76.10	03550	OUTPATIENT PSYCH	0.000000		76.10
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,239,495	0	11,239,495	90,466	124.24	30.00
31.00	INTENSIVE CARE UNIT	1,333,394		1,333,394	8,139	163.83	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	1,018,477		1,018,477	6,539	155.75	34.00
41.00	SUBPROVIDER - IRF	806,593	0	806,593	11,289	71.45	41.00
43.00	NURSERY	351,570		351,570	4,048	86.85	43.00
200.00	Total (lines 30-199)	14,749,529		14,749,529	120,481		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	40,458	5,026,502	30.00
31.00	INTENSIVE CARE UNIT	3,333	546,045	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	2,946	458,840	34.00
41.00	SUBPROVIDER - IRF	8,561	611,683	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	55,298	6,643,070	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,988,446	169,605,601	0.023516	31,756,384	746,783	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,704,972	364,989,458	0.007411	68,712,379	509,227	54.00
60.00	06000	LABORATORY	874,814	252,365,088	0.003466	66,293,656	229,774	60.00
65.00	06500	RESPIRATORY THERAPY	206,538	40,923,359	0.005047	19,633,894	99,092	65.00
66.00	06600	PHYSICAL THERAPY	679,807	61,254,487	0.011098	9,712,751	107,792	66.00
69.00	06900	ELECTROCARDIOLOGY	1,017,196	120,700,458	0.008427	30,521,357	257,203	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	180,432	5,283,185	0.034152	799,246	27,296	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	828,640	141,078,308	0.005874	41,036,557	241,049	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,222,129	104,805,148	0.011661	32,908,424	383,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	710,669	159,883,985	0.004445	62,560,107	278,080	73.00
76.00	03950	OTHER ANCILLARY	417,638	36,474,796	0.011450	1,697,033	19,431	76.00
76.10	03550	OUTPATIENT PSYCH	28,482	1,314,333	0.021670	136,264	2,953	76.10
76.97	07697	CARDIAC REHABILITATION	220,702	2,165,181	0.101932	5,297	540	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,555,034	152,722,386	0.010182	26,440,247	269,215	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,335,451	23,663,327	0.056435	3,973,363	224,237	92.00
200.00		Total (lines 50-199)	15,970,950	1,637,229,100		396,186,959	3,396,417	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | 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	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	90,466	0.00	40,458	0		30.00
31.00	03100	INTENSIVE CARE UNIT	8,139	0.00	3,333	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,539	0.00	2,946	0		34.00
41.00	04100	SUBPROVIDER - IRF	11,289	0.00	8,561	0		41.00
43.00	04300	NURSERY	4,048	0.00	0	0		43.00
200.00		Total (lines 30-199)	120,481		55,298	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	1,079,792	0	1,079,792	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	1,079,792	0	1,079,792	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	169,605,601	0.000000	0.000000	31,756,384	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	364,989,458	0.000000	0.000000	68,712,379	54.00
60.00	06000	LABORATORY	0	252,365,088	0.000000	0.000000	66,293,656	60.00
65.00	06500	RESPIRATORY THERAPY	0	40,923,359	0.000000	0.000000	19,633,894	65.00
66.00	06600	PHYSICAL THERAPY	0	61,254,487	0.000000	0.000000	9,712,751	66.00
69.00	06900	ELECTROCARDIOLOGY	0	120,700,458	0.000000	0.000000	30,521,357	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,283,185	0.000000	0.000000	799,246	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	141,078,308	0.000000	0.000000	41,036,557	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	104,805,148	0.000000	0.000000	32,908,424	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,079,792	159,883,985	0.006754	0.006754	62,560,107	73.00
76.00	03950	OTHER ANCILLARY	0	36,474,796	0.000000	0.000000	1,697,033	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,314,333	0.000000	0.000000	136,264	76.10
76.97	07697	CARDIAC REHABILITATION	0	2,165,181	0.000000	0.000000	5,297	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	152,722,386	0.000000	0.000000	26,440,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	23,663,327	0.000000	0.000000	3,973,363	92.00
200.00		Total (lines 50-199)	1,079,792	1,637,229,100			396,186,959	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/21/2015 9:30 am

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	25,172,005	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,670,781	0		54.00
60.00	06000	LABORATORY	0	16,983,597	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	890,596	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,321,100	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	26,764,784	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	903,179	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,862,654	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,871,679	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	422,531	10,694,078	72,228		73.00
76.00	03950	OTHER ANCILLARY	0	9,761,323	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	466	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	1,079,867	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	16,495,578	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,209,622	0		92.00
200.00		Total (lines 50-199)	422,531	202,681,309	72,228		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.188315	25,172,005	0	0	4,740,266	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.063750	54,670,781	0	0	3,485,262	54.00
60.00	06000	LABORATORY	0.078140	16,983,597	2,307	0	1,327,098	60.00
65.00	06500	RESPIRATORY THERAPY	0.111488	890,596	0	0	99,291	65.00
66.00	06600	PHYSICAL THERAPY	0.255403	3,321,100	0	0	848,219	66.00
69.00	06900	ELECTROCARDIOLOGY	0.062484	26,764,784	0	0	1,672,371	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.182631	903,179	0	0	164,948	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.165877	16,862,654	11,304	0	2,797,126	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.333238	12,871,679	0	0	4,289,333	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176293	10,694,078	25	65,852	1,885,291	73.00
76.00	03950	OTHER ANCILLARY	0.300975	9,761,323	0	0	2,937,914	76.00
76.10	03550	OUTPATIENT PSYCH	0.501167	466	0	0	234	76.10
76.97	07697	CARDIAC REHABILITATION	0.598321	1,079,867	0	0	646,107	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.112613	16,495,578	0	0	1,857,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416781	6,209,622	0	0	2,588,052	92.00
200.00		Subtotal (see instructions)		202,681,309	13,636	65,852	29,339,129	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		202,681,309	13,636	65,852	29,339,129	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	180	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	1,875	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4	11,609		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	2,059	11,609		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,059	11,609		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,988,446	169,605,601	0.023516	66,958	1,575	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,704,972	364,989,458	0.007411	1,215,676	9,009	54.00
60.00	06000	LABORATORY	874,814	252,365,088	0.003466	3,353,160	11,622	60.00
65.00	06500	RESPIRATORY THERAPY	206,538	40,923,359	0.005047	815,984	4,118	65.00
66.00	06600	PHYSICAL THERAPY	679,807	61,254,487	0.011098	12,187,298	135,255	66.00
69.00	06900	ELECTROCARDIOLOGY	1,017,196	120,700,458	0.008427	360,071	3,034	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	180,432	5,283,185	0.034152	25,032	855	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	828,640	141,078,308	0.005874	1,020,847	5,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,222,129	104,805,148	0.011661	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	710,669	159,883,985	0.004445	3,927,781	17,459	73.00
76.00	03950	OTHER ANCILLARY	417,638	36,474,796	0.011450	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	28,482	1,314,333	0.021670	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	220,702	2,165,181	0.101932	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,555,034	152,722,386	0.010182	25,524	260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	23,663,327	0.000000	0	0	92.00
200.00		Total (lines 50-199)	14,635,499	1,637,229,100		22,998,331	189,183	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	1,079,792	0	1,079,792	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	1,079,792	0	1,079,792	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	169,605,601	0.000000	0.000000	66,958	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	364,989,458	0.000000	0.000000	1,215,676	54.00
60.00	06000	LABORATORY	0	252,365,088	0.000000	0.000000	3,353,160	60.00
65.00	06500	RESPIRATORY THERAPY	0	40,923,359	0.000000	0.000000	815,984	65.00
66.00	06600	PHYSICAL THERAPY	0	61,254,487	0.000000	0.000000	12,187,298	66.00
69.00	06900	ELECTROCARDIOLOGY	0	120,700,458	0.000000	0.000000	360,071	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,283,185	0.000000	0.000000	25,032	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	141,078,308	0.000000	0.000000	1,020,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	104,805,148	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,079,792	159,883,985	0.006754	0.006754	3,927,781	73.00
76.00	03950	OTHER ANCILLARY	0	36,474,796	0.000000	0.000000	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,314,333	0.000000	0.000000	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	2,165,181	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	152,722,386	0.000000	0.000000	25,524	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	23,663,327	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	1,079,792	1,637,229,100			22,998,331	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,655	0		54.00
60.00	06000	LABORATORY	0	606	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	109	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	965	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,279	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,528	1,440	10		73.00
76.00	03950	OTHER ANCILLARY	0	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	26,528	36,054	10		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.188315	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.063750	23,655	0	0	1,508	54.00
60.00	06000	LABORATORY	0.078140	606	0	0	47	60.00
65.00	06500	RESPIRATORY THERAPY	0.111488	109	0	0	12	65.00
66.00	06600	PHYSICAL THERAPY	0.255403	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.062484	965	0	0	60	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.182631	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.165877	9,279	257	0	1,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.333238	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176293	1,440	0	3,400	254	73.00
76.00	03950	OTHER ANCILLARY	0.300975	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.501167	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.598321	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.112613	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416781	0	0	0	0	92.00
200.00		Subtotal (see instructions)		36,054	257	3,400	3,420	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		36,054	257	3,400	3,420	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	599		73.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	43	599		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	43	599		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	1,079,792	0	1,079,792	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	1,079,792	0	1,079,792	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	169,605,601	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	364,989,458	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	252,365,088	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	40,923,359	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	61,254,487	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	120,700,458	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,283,185	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	141,078,308	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	104,805,148	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,079,792	159,883,985	0.006754	0.006754	0	73.00
76.00	03950	OTHER ANCILLARY	0	36,474,796	0.000000	0.000000	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,314,333	0.000000	0.000000	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	2,165,181	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	152,722,386	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	23,663,327	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	1,079,792	1,637,229,100			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
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
76.00	03950	OTHER ANCILLARY	0	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	1,079,792	0	1,079,792	73.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	1,079,792	0	1,079,792	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	169,605,601	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	364,989,458	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	252,365,088	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	40,923,359	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	61,254,487	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	120,700,458	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,283,185	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	141,078,308	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	104,805,148	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,079,792	159,883,985	0.006754	0.006754	0	73.00
76.00	03950	OTHER ANCILLARY	0	36,474,796	0.000000	0.000000	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,314,333	0.000000	0.000000	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	2,165,181	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	152,722,386	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	23,663,327	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	1,079,792	1,637,229,100			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
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
76.00	03950	OTHER ANCILLARY	0	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	90,466	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	90,466	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)	79,717	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)	40,458	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)	83,004,692	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)	83,004,692	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)	83,004,692	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)	917.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	37,121,024	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)	37,121,024	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	13,926,927	8,139	1,711.13	3,333	5,703,196	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	9,662,620	6,539	1,477.69	2,946	4,353,275	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)	56,305,355	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	103,482,850	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)	6,031,387	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,818,948	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	9,850,335	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	93,632,515	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)	10,749	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	917.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	9,862,422	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	11,239,495	83,004,692	0.135408	9,862,422	1,335,451	90.00
91.00	Nursing School cost	0	83,004,692	0.000000	9,862,422	0	91.00
92.00	Allied health cost	0	83,004,692	0.000000	9,862,422	0	92.00
93.00	All other Medical Education	0	83,004,692	0.000000	9,862,422	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140007 Component CCN: 14T007	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/21/2015 9:30 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,289	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,289	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)	11,289	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)	8,561	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)	7,766,295	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,766,295	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)	7,766,295	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)	687.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,889,540	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,889,540	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 14T007 | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	4,447,831	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,337,371	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)	611,683	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	215,711	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	827,394	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,509,977	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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 14T007 | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	806,593	7,766,295	0.103858	0	0	90.00
91.00	Nursing School cost	0	7,766,295	0.000000	0	0	91.00
92.00	Allied health cost	0	7,766,295	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,766,295	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	90,466	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	90,466	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)	79,717	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	15,153	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)	4,048	15.00
16.00	Nursery days (title V or XIX only)	2,607	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)	82,913,852	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)	82,913,852	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)	82,913,852	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)	916.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,888,028	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	13,888,028	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	3,051,944	4,048	753.94	2,607	1,965,522	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	13,895,176	8,139	1,707.23	1,122	1,915,512	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	9,662,620	6,539	1,477.69	650	960,499	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	18,729,561	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	10,749	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	916.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	9,851,673	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	11,239,495	82,913,852	0.135556	9,851,673	1,335,453	90.00
91.00	Nursing School cost	0	82,913,852	0.000000	9,851,673	0	91.00
92.00	Allied health cost	0	82,913,852	0.000000	9,851,673	0	92.00
93.00	All other Medical Education	0	82,913,852	0.000000	9,851,673	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140007 Component CCN: 14T007	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/21/2015 9:30 am
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,289	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,289	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)	11,289	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)	305	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)	4,048	15.00
16.00	Nursery days (title V or XIX only)	2,607	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)	7,766,295	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,766,295	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)	7,766,295	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)	687.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	209,825	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)	209,825	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 14T007 | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	209,825	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 14T007 | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	806,593	7,766,295	0.103858	0	0	90.00
91.00	Nursing School cost	0	7,766,295	0.000000	0	0	91.00
92.00	Allied health cost	0	7,766,295	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,766,295	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		78,936,307		30.00
31.00	03100	INTENSIVE CARE UNIT		20,978,245		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		17,115,589		34.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.188315	31,756,384	5,980,203	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.063750	68,712,379	4,380,414	54.00
60.00	06000	LABORATORY	0.078140	66,293,656	5,180,186	60.00
65.00	06500	RESPIRATORY THERAPY	0.111594	19,633,894	2,191,025	65.00
66.00	06600	PHYSICAL THERAPY	0.255403	9,712,751	2,480,666	66.00
69.00	06900	ELECTROCARDIOLOGY	0.063197	30,521,357	1,928,858	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.182631	799,246	145,967	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.165877	41,036,557	6,807,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.333238	32,908,424	10,966,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176293	62,560,107	11,028,909	73.00
76.00	03950	OTHER ANCILLARY	0.300979	1,697,033	510,771	76.00
76.10	03550	OUTPATIENT PSYCH	0.501167	136,264	68,291	76.10
76.97	07697	CARDIAC REHABILITATION	0.598321	5,297	3,169	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.112613	26,440,247	2,977,516	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416781	3,973,363	1,656,022	92.00
200.00		Total (sum of lines 50-94 and 96-98)		396,186,959	56,305,355	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		396,186,959		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
41.00	04100	SUBPROVIDER - IRF		15,690,648		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.188315	66,958	12,609	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.063750	1,215,676	77,499	54.00
60.00	06000	LABORATORY	0.078140	3,353,160	262,016	60.00
65.00	06500	RESPIRATORY THERAPY	0.111594	815,984	91,059	65.00
66.00	06600	PHYSICAL THERAPY	0.255403	12,187,298	3,112,672	66.00
69.00	06900	ELECTROCARDIOLOGY	0.063197	360,071	22,755	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.182631	25,032	4,572	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.165877	1,020,847	169,335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.333238	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176293	3,927,781	692,440	73.00
76.00	03950	OTHER ANCILLARY	0.300979	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.501167	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.598321	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.112613	25,524	2,874	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416781	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		22,998,331	4,447,831	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		22,998,331		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		60,415,407		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		20,084,912		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		1,911,237		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		13,293,663		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		385.55		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		9.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		5.85		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		5.85		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		9.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		1.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		1.00		12.00
13.00	Total allowable FTE count for the prior year.		0.94		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		1.04		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.99		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.99		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.002568		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.002847		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.002568		21.00
22.00	IME payment adjustment (see instructions)		131,593		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-8.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		131,593		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.97		30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.57		31.00
32.00	Sum of lines 30 and 31		24.54		32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.46		33.00
34.00	Disproportionate share adjustment (see instructions)		1,903,833		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/21/2015 9:30 am

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000492950	0.000499498	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		4,457,416	3,819,984	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		3,333,902	962,846	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		4,296,748		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		88,743,730		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		88,743,730		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		7,046,000		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		49,776		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		21,156		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		422,531		58.00
59.00	Total (sum of amounts on lines 49 through 58)		96,283,193		59.00
60.00	Primary payer payments		14,917		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		96,268,276		61.00
62.00	Deductibles billed to program beneficiaries		7,578,784		62.00
63.00	Coinsurance billed to program beneficiaries		483,048		63.00
64.00	Allowable bad debts (see instructions)		1,151,549		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		748,507		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,027,213		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		88,954,951		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		46,950		70.93
70.94	HRR adjustment amount (see instructions)		-1,202,292		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/21/2015 9:30 am

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		87,799,609		71.00
71.01	Sequestration adjustment (see instructions)		1,755,992		71.01
72.00	Interim payments		84,054,376		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		1,989,241		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		92,574		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140007	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/21/2015 9:30 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	13,668	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	29,266,901	2.00
3.00	PPS payments	28,742,494	3.00
4.00	Outlier payment (see instructions)	22,141	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	72,228	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	13,668	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	79,488	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)	79,488	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	79,488	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	65,820	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)	13,668	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)	28,836,863	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	2,261	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,756,145	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)	23,092,125	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	12,835	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)	23,104,960	30.00
31.00	Primary payer payments	11,687	31.00
32.00	Subtotal (line 30 minus line 31)	23,093,273	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)	546,362	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	355,135	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	531,392	36.00
37.00	Subtotal (see instructions)	23,448,408	37.00
38.00	MSP-LCC reconciliation amount from PS&R	45	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)	23,448,363	40.00
40.01	Sequestration adjustment (see instructions)	468,967	40.01
41.00	Interim payments	22,919,411	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	59,985	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140007 Component CCN: 14T007	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/21/2015 9:30 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	642	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,410	2.00
3.00	PPS payments	2,784	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	10	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	642	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,657	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)	3,657	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	3,657	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,015	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)	642	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)	2,794	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	51	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	452	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)	2,933	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,933	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,933	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,933	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)	2,933	40.00
40.01	Sequestration adjustment (see instructions)	59	40.01
41.00	Interim payments	2,903	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-29	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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2015 9:30 am

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		83,353,812		22,543,067	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		599,613		367,426	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	08/12/2014	100,951	08/12/2014	8,918	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)		100,951		8,918	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)		84,054,376		22,919,411	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		1,989,241		59,985	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		86,043,617		22,979,396	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140007 | Component CCN: 14T007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2015 9:30 am

Title XVIII | Subprovider - IRF | 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		11,942,027		2,903	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)		11,942,027		2,903	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		126,249		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		29	6.02
7.00	Total Medicare program liability (see instructions)		12,068,276		2,874	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: 140007	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/21/2015 9:30 am
	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	21,735	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	46,737	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	7,877	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	94,395	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,912,060,830	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	53,478,200	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)	2,730,718	8.00
9.00	Sequestration adjustment amount (see instructions)	54,614	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	2,676,104	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	2,706,092	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)	-29,988	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140007 Component CCN: 14T007	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/21/2015 9:30 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	12,049,170	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0129	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	237,369	3.00
4.00	Outlier Payments	77,910	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	30.928767	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	12,364,449	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	12,364,449	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	12,364,449	19.00
20.00	Deductibles	46,208	20.00
21.00	Subtotal (line 19 minus line 20)	12,318,241	21.00
22.00	Coinsurance	30,400	22.00
23.00	Subtotal (line 21 minus line 22)	12,287,841	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	304	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	198	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	12,288,039	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	26,528	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	12,314,567	32.00
32.01	Sequestration adjustment (see instructions)	246,291	32.01
33.00	Interim payments	11,942,027	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	126,249	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	16,261	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	77,910	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-3 Part VII | Date/Time Prepared: 5/21/2015 9:30 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	18,729,561		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)	18,729,561	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)	18,729,561	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	18,729,561	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)	18,729,561	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140007 Component CCN: 14T007	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/21/2015 9:30 am
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	209,825		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)	209,825	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)	209,825	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	209,825	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)	209,825	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-4 | Date/Time Prepared: 5/21/2015 9:30 am

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.			9.00	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)			5.85	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))			0.00	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)			5.85	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			9.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			1.00	6.00
7.00	Enter the lesser of line 5 or line 6			1.00	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.	1.00	0.00	1.00	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.	1.00	0.00	1.00	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	1.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.44	0.37		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.96	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.80	0.12		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	0.80	0.12		17.00
18.00	Per resident amount	114,941.00	114,941.00		18.00
19.00	Approved amount for resident costs	91,953	13,793	105,746	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)			105,746	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	55,298	8,474		26.00
27.00	Total Inpatient Days (see instructions)	105,684	105,684		27.00
28.00	Ratio of inpatient days to total inpatient days	0.523239	0.080182		28.00
29.00	Program direct GME amount	55,330	8,479		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		1,198		30.00
31.00	Net Program direct GME amount			62,611	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 140007	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/21/2015 9:30 am
	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)	0	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)	113,820,221	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)	14,917	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	113,805,304	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	29,356,859	42.00
43.00	Primary payer payments (see instructions)	11,687	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	29,345,172	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	143,150,476	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.795005	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.204995	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	62,611	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	49,776	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	12,835	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/21/2015 9:30 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	13,454,000	0	0	0	1.00
2.00	Temporary investments	1,539,000	0	0	0	2.00
3.00	Notes receivable	71,000	0	0	0	3.00
4.00	Accounts receivable	75,992,000	0	0	0	4.00
5.00	Other receivable	5,508,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	8,851,000	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	-249,000	0	0	0	9.00
10.00	Due from other funds	5,055,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	110,221,000	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	219,548,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	219,548,000	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	5,055,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,055,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	334,824,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	25,343,000	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)	874,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	2,030,000	0	0	0	43.00
44.00	Other current liabilities	56,759,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	85,006,000	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	4,487,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	4,487,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	89,493,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	245,331,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	245,331,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	334,824,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/21/2015 9:30 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		259,820,135		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,008,413				2.00
3.00	Total (sum of line 1 and line 2)		269,828,548		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		269,828,548		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ASSETS RELEASED FROM RESTRICTIONS	24,497,548		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)		24,497,548		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		245,331,000		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	ASSETS RELEASED FROM RESTRICTIONS		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: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/21/2015 9:30 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	180,462,495		180,462,495	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	20,467,294		20,467,294	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)	200,929,789		200,929,789	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	43,120,374		43,120,374	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	31,129,190		31,129,190	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	74,249,564		74,249,564	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	275,179,353		275,179,353	17.00
18.00	Ancillary services	798,619,204	838,287,958	1,636,907,162	18.00
19.00	Outpatient services	0	11,667,883	11,667,883	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,073,798,557	849,955,841	1,923,754,398	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		374,405,501		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)		374,405,501		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140007 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/21/2015 9:30 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,923,754,398	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,547,793,308	2.00
3.00	Net patient revenues (line 1 minus line 2)	375,961,090	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	374,405,501	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,555,589	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	ALL OTHER	8,251,583	24.00
24.01	OTHER GAINS	201,241	24.01
25.00	Total other income (sum of lines 6-24)	8,452,824	25.00
26.00	Total (line 5 plus line 25)	10,008,413	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)	10,008,413	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140007	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/21/2015 9:30 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	6,433,918	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	276,875	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	258.62	3.00
4.00	Number of interns & residents (see instructions)	0.99	4.00
5.00	Indirect medical education percentage (see instructions)	0.11	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	7,077	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.97	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	20.57	8.00
9.00	Sum of lines 7 and 8	24.54	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.10	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	328,130	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	7,046,000	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00