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: 140058	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/25/2015 2:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2015 Time: 2:05 pm
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 PASSAVANT AREA HOSPITAL (140058) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 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	-61,274	10,321	1,143,733	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	40		0	7.00
200.00	Total	0	-61,274	10,361	1,143,733	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2015 2:04 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1600 WEST WALNUT	PO Box:			1.00
2.00	City: JACKSONVILLE	State: IL	Zip Code: 62650-1185	County: MORGAN	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	PASSAVANT AREA HOSPITAL	140058	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	PASSAVANT AREA HOSPITAL	145951	99914		10/31/1997	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2013	09/30/2014	20.00
21.00	Type of Control (see instructions)	2		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)		N	22.01
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.	1	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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,035	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

		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.	2		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.	2		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.	1		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2015 2:04 pm

		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.	10/01/2013	09/30/2014	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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part 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, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2015 2:04 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
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 Non-Provider Settings		
63.00	Has your facility trained residents in non-provider 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 non-provider 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

		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 non-provider 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2015 2:04 pm

		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. 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 respectively 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 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively 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 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140058	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/25/2015 2:04 pm

		V	XIX	
		1.00	2.00	
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 Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part 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.	N	N	N	N	109.00

		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 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 hospital providers) based on the definition in CMS 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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	195,595	0	0	118.01

		V	XIX	
		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
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	14H058	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2015 2:04 pm

	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: MEMORIAL HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	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 they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

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

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

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2015 2:04 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for 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)		Y	12/10/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2015 2:04 pm

		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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	STLHEALTHCARE@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2015 2:04 pm

		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)	12/10/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGING DIRECTOR		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: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2015 2:04 pm

	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	84	30,660	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)		84	30,660	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9	3,285	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		93	33,945	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	15	5,475		0	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)		108				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: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2015 2:04 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,932	1,454	8,500			1.00
2.00	HMO and other (see instructions)	463	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,932	1,454	8,500			7.00
8.00	INTENSIVE CARE UNIT	803	140	1,210			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		441	723			13.00
14.00	Total (see instructions)	5,735	2,035	10,433	0.00	653.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,956	0	3,619	0.00	16.38	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	669.80	27.00
28.00	Observation Bed Days		160	776			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			218			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	142			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: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2015 2:04 pm

	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	1,506	481	2,943	1.00
2.00	HMO and other (see instructions)			127	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,506	481	2,943	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part II Date/Time Prepared: 2/25/2015 2:04 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	32,308,770	0	32,308,770	1,393,187.93	23.19	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	753,522	0	753,522	34,080.43	22.11	9.00
10.00	Excluded area salaries (see instructions)		17,363	0	17,363	755.10	22.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		135,025	0	135,025	3,345.15	40.36	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		86,248	0	86,248	299.50	287.97	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,314,688	0	12,314,688			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		310,636	0	310,636			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	213,509	0	213,509	8,399.30	25.42	26.00
27.00	Administrative & General	5.00	5,702,924	0	5,702,924	230,693.31	24.72	27.00
28.00	Administrative & General under contract (see inst.)		893,857	0	893,857	13,611.00	65.67	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	986,628	0	986,628	38,335.75	25.74	30.00
31.00	Laundry & Linen Service	8.00	223,748	0	223,748	17,718.44	12.63	31.00
32.00	Housekeeping	9.00	883,923	0	883,923	74,413.45	11.88	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,128,343	-815,792	312,551	22,681.89	13.78	34.00
35.00	Dietary under contract (see instructions)		405	0	405	12.50	32.40	35.00
36.00	Cafeteria	11.00	0	815,792	815,792	59,202.20	13.78	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	712,411	0	712,411	21,166.70	33.66	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	750,302	0	750,302	21,624.73	34.70	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part II Date/Time Prepared: 2/25/2015 2:04 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	587,743	0	587,743	32,592.34	18.03	41.00
42.00	Social Service	17.00	59,925	0	59,925	2,324.54	25.78	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part III Date/Time Prepared: 2/25/2015 2:04 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		33,203,032	0	33,203,032	1,406,811.43	23.60	1.00
2.00	Excluded area salaries (see instructions)		770,885	0	770,885	34,835.53	22.13	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,432,147	0	32,432,147	1,371,975.90	23.64	3.00
4.00	Subtotal other wages & related costs (see inst.)		221,273	0	221,273	3,644.65	60.71	4.00
5.00	Subtotal wage-related costs (see inst.)		12,314,688	0	12,314,688	0.00	37.97	5.00
6.00	Total (sum of lines 3 thru 5)		44,968,108	0	44,968,108	1,375,620.55	32.69	6.00
7.00	Total overhead cost (see instructions)		12,143,718	0	12,143,718	542,776.15	22.37	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part IV Date/Time Prepared: 2/25/2015 2:04 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,542,549	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	8,212,314	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24,599	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)	165,060	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	196,959	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	2,440,971	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	5,466	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	37,406	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,625,324	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part V Date/Time Prepared: 2/25/2015 2:04 pm

	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	1,115,535	0	1.00
2.00	Hospital	1,115,535	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	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: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-7 | Date/Time Prepared: 2/25/2015 2:04 pm

		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.	N		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.	N		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	51	0	51	7.00
8.00		RHL	91	0	91	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	35	0	35	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	33	0	33	14.00
15.00		RVC	47	0	47	15.00
16.00		RVB	10	0	10	16.00
17.00		RVA	490	0	490	17.00
18.00		RHC	227	0	227	18.00
19.00		RHB	8	0	8	19.00
20.00		RHA	1,263	0	1,263	20.00
21.00		RMC	88	0	88	21.00
22.00		RMB	42	0	42	22.00
23.00		RMA	375	0	375	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	6	0	6	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	7	0	7	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	12	0	12	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	7	0	7	35.00
36.00		HB1	19	0	19	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	57	0	57	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	2	0	2	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	2	0	2	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	11	0	11	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	31	0	31	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	22	0	22	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	4	0	4	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	5	0	5	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-7 | Date/Time Prepared: 2/25/2015 2:04 pm

		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	2	0	2	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	3	0	3	78.00
199.00		AAA	6	0	6	199.00
200.00	TOTAL		2,956	0	2,956	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).	99914	99914	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	753,522	21.74	Y	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)	3,466,808			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 2/25/2015 2:04 pm

		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)	0.282636	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,993,788	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?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	5,522,885	5.00
6.00	Medicaid charges	42,786,392	6.00
7.00	Medicaid cost (line 1 times line 6)	12,092,975	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)	1,576,302	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	49,959	9.00
10.00	Stand-alone SCHIP charges	565,883	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	159,939	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	109,980	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)	1,686,282	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	8,168,565	0	8,168,565	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,308,731	0	2,308,731	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,308,731	0	2,308,731	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)	335,420	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	585,636	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-250,216	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-70,720	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,238,011	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,924,293	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/25/2015 2:04 pm

		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		2,543,762	2,543,762	1,139,196	3,682,958	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,867,990	2,867,990	152,945	3,020,935	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	213,509	12,854,799	13,068,308	0	13,068,308	4.00
5.01	00540	NONPATIENT TELEPHONES	0	53,828	53,828	0	53,828	5.01
5.02	00550	DATA PROCESSING	976,845	1,399,096	2,375,941	0	2,375,941	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	297,259	156,750	454,009	0	454,009	5.03
5.04	00570	ADMITTING	635,504	20,553	656,057	0	656,057	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	686,366	614,417	1,300,783	0	1,300,783	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	3,106,950	7,134,056	10,241,006	-125,789	10,115,217	5.06
7.00	00700	OPERATION OF PLANT	986,628	2,031,791	3,018,419	-109,008	2,909,411	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	223,748	110,993	334,741	0	334,741	8.00
9.00	00900	HOUSEKEEPING	883,923	137,818	1,021,741	0	1,021,741	9.00
10.00	01000	DIETARY	1,128,343	1,095,042	2,223,385	-1,607,507	615,878	10.00
11.00	01100	CAFETERIA	0	0	0	1,607,507	1,607,507	11.00
13.00	01300	NURSING ADMINISTRATION	712,411	67,715	780,126	0	780,126	13.00
15.00	01500	PHARMACY	750,302	2,770,761	3,521,063	-2,319,400	1,201,663	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	587,743	83,956	671,699	0	671,699	16.00
17.00	01700	SOCIAL SERVICE	59,925	0	59,925	0	59,925	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,794,403	807,063	4,601,466	-992	4,600,474	30.00
31.00	03100	INTENSIVE CARE UNIT	1,048,663	63,650	1,112,313	-360	1,111,953	31.00
43.00	04300	NURSERY	325,540	39,047	364,587	0	364,587	43.00
44.00	04400	SKILLED NURSING FACILITY	753,522	53,714	807,236	-129	807,107	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,875,054	5,213,259	9,088,313	-1,748,937	7,339,376	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	81,386	9,762	91,148	0	91,148	52.00
53.00	05300	ANESTHESIOLOGY	50,824	312,572	363,396	0	363,396	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,201,377	1,170,787	3,372,164	0	3,372,164	54.00
60.00	06000	LABORATORY	1,912,138	1,975,878	3,888,016	0	3,888,016	60.00
65.00	06500	RESPIRATORY THERAPY	652,926	259,975	912,901	0	912,901	65.00
66.00	06600	PHYSICAL THERAPY	2,361,755	397,866	2,759,621	0	2,759,621	66.00
68.00	06800	SPEECH PATHOLOGY	177,909	6,902	184,811	0	184,811	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,205	150	5,355	0	5,355	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,245	452,127	565,372	-20,447	544,925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,769,384	1,769,384	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,320,881	2,320,881	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	128,803	17,090	145,893	0	145,893	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	89,216	28,552	117,768	0	117,768	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,840	40	1,880	0	1,880	90.00
91.00	09100	EMERGENCY	3,468,145	1,679,672	5,147,817	0	5,147,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,166,352	1,166,352	-1,166,352	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,291,407	47,597,785	79,889,192	-109,008	79,780,184	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,547	11,075	28,622	108,824	137,446	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	-184	0	-184	184	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	32,308,770	47,608,860	79,917,630	0	79,917,630	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	686,385	4,369,343		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	798,719	3,819,654		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,454,480	10,613,828		4.00
5.01	00540	NONPATIENT TELEPHONES	-8,630	45,198		5.01
5.02	00550	DATA PROCESSING	0	2,375,941		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	454,009		5.03
5.04	00570	ADMITTING	0	656,057		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,300,783		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-2,633,189	7,482,028		5.06
7.00	00700	OPERATION OF PLANT	-16,223	2,893,188		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	334,741		8.00
9.00	00900	HOUSEKEEPING	0	1,021,741		9.00
10.00	01000	DIETARY	-49,420	566,458		10.00
11.00	01100	CAFETERIA	-459,609	1,147,898		11.00
13.00	01300	NURSING ADMINISTRATION	-2,540	777,586		13.00
15.00	01500	PHARMACY	-300	1,201,363		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-33,931	637,768		16.00
17.00	01700	SOCIAL SERVICE	0	59,925		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-506,255	4,094,219		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,111,953		31.00
43.00	04300	NURSERY	0	364,587		43.00
44.00	04400	SKILLED NURSING FACILITY	0	807,107		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-4,520	7,334,856		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	91,148		52.00
53.00	05300	ANESTHESIOLOGY	0	363,396		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-973	3,371,191		54.00
60.00	06000	LABORATORY	-75,000	3,813,016		60.00
65.00	06500	RESPIRATORY THERAPY	0	912,901		65.00
66.00	06600	PHYSICAL THERAPY	-198,793	2,560,828		66.00
68.00	06800	SPEECH PATHOLOGY	0	184,811		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,355		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	544,925		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,769,384		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,320,881		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	-384	145,509		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-896	116,872		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	1,880		90.00
91.00	09100	EMERGENCY	-1,069,685	4,078,132		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)	-6,029,724	73,750,460		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	137,446		192.00
192.01	19201	RENTED SPACE	0	0		192.01
194.00	07950	FUND DEVELOPMENT	0	0		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-6,029,724	73,887,906		200.00

RECLASSIFICATIONS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/25/2015 2:04 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	815,792	791,715		1.00
	TOTALS		815,792	791,715		
	B - RECLASS SPOILED DRUGS EXPENSE					
1.00	PHARMACY	15.00	0	1,481		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	1,481		
	C - RECLASS CHARGEABLE DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,320,881		1.00
	TOTALS		0	2,320,881		
	D - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,053,132		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	113,220		2.00
	TOTALS		0	1,166,352		
	E - RECLASS PROPERTY INSURANCE EXPENSE					
1.00	OTHER CAP REL COSTS	3.00	0	125,789		1.00
	TOTALS		0	125,789		
	F - RECLASS FUND DEVELOPMENT COSTS					
1.00	FUND DEVELOPMENT	194.00	184	0		1.00
	TOTALS		184	0		
	G - RECLASS REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	109,008		1.00
	TOTALS		0	109,008		
	H - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,769,384		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,769,384		
500.00	Grand Total: Increases		815,976	6,284,610		500.00

RECLASSIFICATIONS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/25/2015 2:04 pm

		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	815,792	791,715	0		1.00
	TOTALS		815,792	791,715			
	B - RECLASS SPOILED DRUGS EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	992	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	360	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	129	0		3.00
	TOTALS		0	1,481			
	C - RECLASS CHARGEABLE DRUG COSTS						
1.00	PHARMACY	15.00	0	2,320,881	0		1.00
	TOTALS		0	2,320,881			
	D - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,166,352	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	1,166,352			
	E - RECLASS PROPERTY INSURANCE EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	125,789	12		1.00
	TOTALS		0	125,789			
	F - RECLASS FUND DEVELOPMENT COSTS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	184	0	0		1.00
	TOTALS		184	0			
	G - RECLASS REAL ESTATE TAXES						
1.00	OPERATION OF PLANT	7.00	0	109,008	0		1.00
	TOTALS		0	109,008			
	H - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	1,748,937	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	20,447	0		2.00
	TOTALS		0	1,769,384			
500.00	Grand Total: Decreases		815,976	6,284,610			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2015 2:04 pm

		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	242,737	0	0	0	0	1.00
2.00	Land Improvements	3,227,192	0	0	0	0	2.00
3.00	Buildings and Fixtures	39,999,025	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	45,175,224	0	0	0	0	5.00
6.00	Movable Equipment	41,470,875	808,814	0	808,814	2,184,719	6.00
7.00	HIT designated Assets	1,757,341	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	131,872,394	808,814	0	808,814	2,184,719	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	131,872,394	808,814	0	808,814	2,184,719	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	242,737	0	1.00
2.00	Land Improvements	3,227,192	0	2.00
3.00	Buildings and Fixtures	39,999,025	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	45,175,224	0	5.00
6.00	Movable Equipment	40,094,970	0	6.00
7.00	HIT designated Assets	1,757,341	0	7.00
8.00	Subtotal (sum of lines 1-7)	130,496,489	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	130,496,489	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2015 2:04 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,160,704	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,867,990	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,028,694	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	383,058	2,543,762	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,867,990	2.00
3.00	Total (sum of lines 1-2)	383,058	5,411,752	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part III | Date/Time Prepared: 2/25/2015 2:04 pm

	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	88,644,178	0	88,644,178	0.684194	86,064	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	41,852,311	936,535	40,915,776	0.315806	39,725	2.00
3.00	Total (sum of lines 1-2)	130,496,489	936,535	129,559,954	1.000000	125,789	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	86,064	2,957,718	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	39,725	3,678,602	0	2.00
3.00	Total (sum of lines 1-2)	0	0	125,789	6,636,320	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	942,503	86,064	0	383,058	4,369,343	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	101,327	39,725	0	0	3,819,654	2.00
3.00	Total (sum of lines 1-2)	1,043,830	125,789	0	383,058	8,188,997	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/25/2015 2:04 pm

	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)	B	-110,629	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-11,893	CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	A	-8,630	NONPATIENT TELEPHONES	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-16,223	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,738,799			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	2,667,600			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-459,609	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-33,931	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-4,628	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HEALTH EDUCATION	B	-2,870	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/25/2015 2:04 pm

	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	
33.01	MISCELLANEOUS INCOME	B	-130,773	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.01
33.02	WEE CARE	B	-663	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.02
33.03	DOORBELL DINNERS	B	-44,792	DIETARY	10.00	0	33.03
33.04	CHILDBIRTH PREP	B	-530	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.04
33.05	MISCELLANEOUS NURSE ADMIN INCOME	B	-2,540	NURSING ADMINISTRATION	13.00	0	33.05
33.06	MISCELLANEOUS PT INCOME	B	-157,648	PHYSICAL THERAPY	66.00	0	33.06
33.07	MISCELLANEOUS ER INCOME	B	-4,936	EMERGENCY	91.00	0	33.07
33.08	MISCELLANEOUS WOC CONTRACTUAL INCOME	B	-1,481	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.08
33.09	INDUSTRIAL REHAB CABLE EXPENSE	A	-601	PHYSICAL THERAPY	66.00	0	33.09
33.10	HYPERBARICS CABLE EXPENSE	A	-896	HYPERBARIC OXYGEN THERAPY	76.98	0	33.10
33.11	TELEPHONE CRC	A	-138	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.11
33.12	INTERMEDIARY DEPRECIATION ADJUSTMENT	A	30,552	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13	INTERMEDIARY DEPRECIATION ADJUSTMENT	A	-13,497	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	SELF INSURANCE	A	-2,364,878	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	PHYSICIAN RECRUITMENT	A	-189,333	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.15
33.16	PARAMEDIC SALARY EXPENSE	A	-19,531	EMERGENCY	91.00	0	33.16
33.17	PARAMEDIC EMPLOYEE BENEFIT EXPENSE	A	-6,328	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	PARAMEDIC OTHER EXPENSE	A	-1,352	EMERGENCY	91.00	0	33.18
33.19	PARAMEDIC CRC EXPENSE	A	-386	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20	INCOME TAX EXPENSE	A	-14,096	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.20
33.21	LOBBYING EXPENSE	A	-36,166	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.21
33.22	COMMUNITY RELATIONS SALARY EXPENSE	A	-257,020	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.22
33.23	COMMUNITY RELATIONS BENEFITS EXPENS	A	-83,274	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	COMMUNITY RELATIONS OTHER EXPENSE	A	-306,794	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.24
33.25	ALCOHOL EXPENSE	A	-104	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.25
33.26	TRUST ACCOUNT FEES	A	56,309	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.26
33.27	LIFE LINE EXPENSES	A	-64,061	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.27
33.28	PROVIDER TAX EXPENSE	A	-3,393,204	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.28
33.29	PROMOTIONAL ITEMS	A	-384	CARDIAC REHABILITATION	76.97	0	33.29
33.30	PROMOTIONAL ITEMS	A	-973	RADIOLOGY-DIAGNOSTIC	54.00	0	33.30
33.31	PROMOTIONAL ITEMS	A	-805	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.31
33.32	EDUCATION INCOME - AHA	B	-17,836	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.32
33.33	PHARMACY MISCELLANEOUS INCOME	B	-300	PHARMACY	15.00	0	33.33
33.34	EMPLOYEE SERVICES INCOME	B	-11,406	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.34
33.35	NONALLOWABLE MEMBERSHIP DUES	A	-390	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.35
33.36	PHYSICIAN LOAN FORGIVENESS	A	-142,901	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.36
33.37	AFFILIATION LEGAL FEES	A	-534,726	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.37
33.38	REVALUED ASSETS DEPRECIATION ADJ	A	771,651	CAP REL COSTS-BLDG & FIXT	1.00	9	33.38
33.39	REVALUED ASSETS DEPRECIATION ADJ	A	636,119	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.39
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,029,724				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

ADJUSTMENTS TO EXPENSES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/25/2015 2:04 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

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: 140058	Period: From 10/01/2013 To 09/30/2014	Worksheet A-8-1 Date/Time Prepared: 2/25/2015 2:04 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAP BLDG HO	8,308	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAP MME HO MME CAP	175,017	0	2.00
3.00	5.06	OTHER ADMINISTRATIVE AND GEN	HO INTEREST	21,346	0	3.00
4.00	5.06	OTHER ADMINISTRATIVE AND GEN	A&G HO MANAGEMENT	2,420,929	0	4.00
4.01	66.00	PHYSICAL THERAPY	DR. SHEAFF DIRECTORSHIP	30,000	0	4.01
4.02	5.06	OTHER ADMINISTRATIVE AND GEN	DR. SHEAFF MEDICAL STAFF PRE	12,000	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,667,600	0	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		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	C		0.00	PPA	100.00	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: 140058	Period: From 10/01/2013 To 09/30/2014	Worksheet A-8-1 Date/Time Prepared: 2/25/2015 2:04 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	8,308	9		1.00
2.00	175,017	9		2.00
3.00	21,346	0		3.00
4.00	2,420,929	0		4.00
4.01	30,000	0		4.01
4.02	12,000	0		4.02
5.00	2,667,600			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	HOME OFFICE		6.00
7.00	PHYSICIAN ORG		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: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2015 2:04 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	30,747	30,747	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	506,255	506,255	0	0	0	2.00
3.00	50.00	OPERATING ROOM	4,520	4,520	0	0	0	3.00
4.00	60.00	LABORATORY	75,000	75,000	0	0	0	4.00
5.00	91.00	EMERGENCY	1,015,752	1,015,752	0	0	0	5.00
6.00	91.00	EMERGENCY	44,248	0	44,248	159,800	210	6.00
7.00	66.00	PHYSICAL THERAPY	44,325	44,325	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	30,000	0	30,000	182,900	43	8.00
9.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	12,000	0	12,000	182,900	47	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,762,847	1,676,599	86,248		300	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	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	16,134	807	0	0	0	6.00
7.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	3,781	189	0	0	0	8.00
9.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	4,133	207	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			24,048	1,203	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	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	30,747		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	506,255		2.00
3.00	50.00	OPERATING ROOM	0	0	0	4,520		3.00
4.00	60.00	LABORATORY	0	0	0	75,000		4.00
5.00	91.00	EMERGENCY	0	0	0	1,015,752		5.00
6.00	91.00	EMERGENCY	0	16,134	28,114	28,114		6.00
7.00	66.00	PHYSICAL THERAPY	0	0	0	44,325		7.00
8.00	66.00	PHYSICAL THERAPY	0	3,781	26,219	26,219		8.00
9.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	4,133	7,867	7,867		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	24,048	62,200	1,738,799		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,369,343	4,369,343				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,819,654		3,819,654			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,613,828	100,458	15,721	10,730,007		4.00
5.01	00540	NONPATIENT TELEPHONES	45,198	13,307	472	0	58,977	5.01
5.02	00550	DATA PROCESSING	2,375,941	47,646	912,526	329,415	3,753	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	454,009	112,349	5	100,243	1,001	5.03
5.04	00570	ADMITTING	656,057	16,397	742	214,307	1,438	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,300,783	31,989	523	231,458	1,313	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	7,482,028	341,441	310,649	961,062	7,319	5.06
7.00	00700	OPERATION OF PLANT	2,893,188	540,263	54,118	332,714	2,377	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	334,741	90,143	11,409	75,453	250	8.00
9.00	00900	HOUSEKEEPING	1,021,741	172,032	3,707	298,079	563	9.00
10.00	01000	DIETARY	566,458	116,839	43,807	105,399	1,939	10.00
11.00	01100	CAFETERIA	1,147,898	49,802	0	275,104	0	11.00
13.00	01300	NURSING ADMINISTRATION	777,586	27,886	0	240,241	938	13.00
15.00	01500	PHARMACY	1,201,363	42,127	4,645	253,019	1,188	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	637,768	61,179	0	198,200	1,438	16.00
17.00	01700	SOCIAL SERVICE	59,925	0	0	20,208	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,094,219	488,241	110,962	1,279,560	5,003	30.00
31.00	03100	INTENSIVE CARE UNIT	1,111,953	86,925	31,092	353,633	1,001	31.00
43.00	04300	NURSERY	364,587	12,503	0	109,780	0	43.00
44.00	04400	SKILLED NURSING FACILITY	807,107	87,810	10,035	254,105	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,334,856	295,758	792,345	1,306,764	7,317	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,148	25,666	0	27,445	0	52.00
53.00	05300	ANESTHESIOLOGY	363,396	16,719	72,344	17,139	1,376	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,371,191	212,019	938,890	742,355	3,002	54.00
60.00	06000	LABORATORY	3,813,016	135,521	88,677	644,817	2,939	60.00
65.00	06500	RESPIRATORY THERAPY	912,901	72,716	42,991	220,182	1,188	65.00
66.00	06600	PHYSICAL THERAPY	2,560,828	191,019	12,748	796,438	3,190	66.00
68.00	06800	SPEECH PATHOLOGY	184,811	5,037	640	59,995	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,355	3,685	4,183	1,755	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	544,925	83,868	69,203	38,189	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,769,384	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,320,881	3,942	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	145,509	30,799	15,616	43,435	313	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	116,872	20,468	0	30,086	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,880	0	0	620	0	90.00
91.00	09100	EMERGENCY	4,078,132	335,133	179,372	1,162,952	5,691	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)	73,750,460	3,871,687	3,727,422	10,724,152	54,537	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,726	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	137,446	2,028	0	5,855	0	192.00
192.01	19201	RENTED SPACE	0	474,902	92,232	0	4,440	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	73,887,906	4,369,343	3,819,654	10,730,007	58,977	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,669,281					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	139,298	806,905				5.03
5.04	00570	ADMITTING	92,865	11,022	992,828			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	278,733	49,670	0	1,894,469		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	325,166	135,015	0	0	9,562,680	5.06
7.00	00700	OPERATION OF PLANT	0	63,868	0	0	3,886,528	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,364	0	0	580,360	8.00
9.00	00900	HOUSEKEEPING	0	121,285	0	0	1,617,407	9.00
10.00	01000	DIETARY	139,298	55,457	0	0	1,029,197	10.00
11.00	01100	CAFETERIA	0	65,845	0	0	1,538,649	11.00
13.00	01300	NURSING ADMINISTRATION	232,301	1,669	0	0	1,280,621	13.00
15.00	01500	PHARMACY	232,301	11,706	0	0	1,746,349	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,298	5,718	0	0	1,043,601	16.00
17.00	01700	SOCIAL SERVICE	46,433	0	0	0	126,566	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	232,301	13,282	58,662	111,931	6,394,161	30.00
31.00	03100	INTENSIVE CARE UNIT	92,865	2,318	19,815	37,808	1,737,410	31.00
43.00	04300	NURSERY	0	842	4,108	7,839	499,659	43.00
44.00	04400	SKILLED NURSING FACILITY	92,865	3,698	13,652	26,050	1,295,322	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,865	62,653	194,102	370,360	10,457,020	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,298	210	4,229	8,070	296,066	52.00
53.00	05300	ANESTHESIOLOGY	0	3,328	18,792	35,857	528,951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,710	271,427	517,983	6,078,577	54.00
60.00	06000	LABORATORY	278,733	54,403	131,526	250,961	5,400,593	60.00
65.00	06500	RESPIRATORY THERAPY	46,433	24,783	48,390	92,331	1,461,915	65.00
66.00	06600	PHYSICAL THERAPY	92,865	1,949	46,856	89,404	3,795,297	66.00
68.00	06800	SPEECH PATHOLOGY	0	576	2,066	3,943	257,068	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13	370	706	16,067	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,285	18,521	35,340	793,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	21,537	41,094	1,832,015	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	72,677	138,672	2,536,172	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,395	1,255	2,394	240,716	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	3,901	7,444	178,771	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	4	8	2,512	90.00
91.00	09100	EMERGENCY	371,599	22,658	60,938	116,274	6,332,749	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)	3,065,517	806,722	992,828	1,894,469	72,546,330	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	20,726	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	145,329	192.00
192.01	19201	RENTED SPACE	603,764	183	0	0	1,175,521	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,669,281	806,905	992,828	1,894,469	73,887,906	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	9,562,680					5.06
7.00	00700	OPERATION OF PLANT	577,775	4,464,303				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	86,277	127,129	793,766			8.00
9.00	00900	HOUSEKEEPING	240,445	242,617	44,565	2,145,034		9.00
10.00	01000	DIETARY	153,001	164,778	8,484	47,359	1,402,819	10.00
11.00	01100	CAFETERIA	228,737	70,237	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	190,378	39,328	0	5,324	0	13.00
15.00	01500	PHARMACY	259,614	59,412	0	35,380	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	155,143	86,281	0	24,689	0	16.00
17.00	01700	SOCIAL SERVICE	18,815	0	0	4,465	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	950,562	688,568	193,764	612,749	560,434	30.00
31.00	03100	INTENSIVE CARE UNIT	258,285	122,591	22,328	49,893	47,261	31.00
43.00	04300	NURSERY	74,280	17,633	8,497	56,677	0	43.00
44.00	04400	SKILLED NURSING FACILITY	192,564	123,839	52,430	78,145	203,371	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,554,581	417,108	220,533	198,454	169,745	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,013	36,196	2,124	14,169	0	52.00
53.00	05300	ANESTHESIOLOGY	78,634	23,579	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	903,647	299,011	55,898	90,811	0	54.00
60.00	06000	LABORATORY	802,858	191,125	391	66,294	0	60.00
65.00	06500	RESPIRATORY THERAPY	217,330	102,552	4,677	60,498	0	65.00
66.00	06600	PHYSICAL THERAPY	564,213	269,395	25,831	65,822	336,470	66.00
68.00	06800	SPEECH PATHOLOGY	38,216	7,103	0	108,029	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,389	5,197	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,937	118,279	0	32,890	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	272,349	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	377,030	5,560	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,785	43,436	280	14,040	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	26,576	28,866	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	373	0	0	0	0	90.00
91.00	09100	EMERGENCY	941,433	472,639	148,530	198,282	85,538	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)	9,363,240	3,762,459	788,332	1,763,970	1,402,819	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,081	29,229	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,605	2,859	0	0	0	192.00
192.01	19201	RENTED SPACE	174,754	669,756	5,434	381,064	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	9,562,680	4,464,303	793,766	2,145,034	1,402,819	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	1,837,623					11.00
13.00	01300	NURSING ADMINISTRATION	41,316	1,556,967				13.00
15.00	01500	PHARMACY	42,209	49,679	2,192,643			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,597	0	0	1,373,311		16.00
17.00	01700	SOCIAL SERVICE	4,546	0	0	0	154,392	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	314,820	370,636	457	81,141	93,391	30.00
31.00	03100	INTENSIVE CARE UNIT	67,128	79,046	301	27,407	13,294	31.00
43.00	04300	NURSERY	22,322	26,272	99	5,683	7,944	43.00
44.00	04400	SKILLED NURSING FACILITY	66,479	78,294	108	18,884	39,763	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	316,403	372,518	44,858	268,479	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,560	6,568	25	5,850	0	52.00
53.00	05300	ANESTHESIOLOGY	56,373	0	80,896	25,993	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	159,825	0	76,435	375,476	0	54.00
60.00	06000	LABORATORY	171,473	0	2,392	181,925	0	60.00
65.00	06500	RESPIRATORY THERAPY	58,768	69,206	19,921	66,932	0	65.00
66.00	06600	PHYSICAL THERAPY	129,021	151,896	2,997	64,810	0	66.00
68.00	06800	SPEECH PATHOLOGY	8,320	9,789	0	2,858	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	487	554	0	512	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,599	0	15,827	25,618	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,790	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,938,940	100,526	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,914	9,306	0	1,736	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	6,169	7,278	7	5,396	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	122	133	0	6	0	90.00
91.00	09100	EMERGENCY	276,711	325,792	9,380	84,289	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)	1,836,162	1,556,967	2,192,643	1,373,311	154,392	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,461	0	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,837,623	1,556,967	2,192,643	1,373,311	154,392	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	10,260,683	0	10,260,683		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,424,944	0	2,424,944		31.00
43.00	04300	NURSERY	0	719,066	0	719,066		43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,149,199	0	2,149,199		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,019,699	0	14,019,699		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	410,571	0	410,571		52.00
53.00	05300	ANESTHESIOLOGY	0	794,426	0	794,426		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,039,680	0	8,039,680		54.00
60.00	06000	LABORATORY	0	6,817,051	0	6,817,051		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,061,799	0	2,061,799		65.00
66.00	06600	PHYSICAL THERAPY	0	5,405,752	0	5,405,752		66.00
68.00	06800	SPEECH PATHOLOGY	0	431,383	0	431,383		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	25,206	0	25,206		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,120,481	0	1,120,481		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,134,154	0	2,134,154		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,958,228	0	4,958,228		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	353,213	0	353,213		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	253,063	0	253,063		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,146	0	3,146		90.00
91.00	09100	EMERGENCY	0	8,875,343	0	8,875,343		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	71,257,087	0	71,257,087		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	53,036	0	53,036		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	171,254	0	171,254		192.00
192.01	19201	RENTED SPACE	0	2,406,529	0	2,406,529		192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	73,887,906	0	73,887,906		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 2:04 pm

		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	100,458	15,721	116,179	116,179	4.00
5.01	00540	NONPATIENT TELEPHONES	0	13,307	472	13,779	0	5.01
5.02	00550	DATA PROCESSING	0	47,646	912,526	960,172	3,566	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	112,349	5	112,354	1,085	5.03
5.04	00570	ADMITTING	0	16,397	742	17,139	2,320	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	31,989	523	32,512	2,506	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	341,441	310,649	652,090	10,405	5.06
7.00	00700	OPERATION OF PLANT	790	540,263	54,118	595,171	3,602	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	90,143	11,409	101,552	817	8.00
9.00	00900	HOUSEKEEPING	0	172,032	3,707	175,739	3,227	9.00
10.00	01000	DIETARY	0	116,839	43,807	160,646	1,141	10.00
11.00	01100	CAFETERIA	0	49,802	0	49,802	2,978	11.00
13.00	01300	NURSING ADMINISTRATION	0	27,886	0	27,886	2,601	13.00
15.00	01500	PHARMACY	4,319	42,127	4,645	51,091	2,739	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	61,179	0	61,179	2,146	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	219	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,493	488,241	110,962	628,696	13,853	30.00
31.00	03100	INTENSIVE CARE UNIT	4,044	86,925	31,092	122,061	3,829	31.00
43.00	04300	NURSERY	9,357	12,503	0	21,860	1,189	43.00
44.00	04400	SKILLED NURSING FACILITY	0	87,810	10,035	97,845	2,751	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,149	295,758	792,345	1,191,252	14,158	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,666	0	25,666	297	52.00
53.00	05300	ANESTHESIOLOGY	9,965	16,719	72,344	99,028	186	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	212,019	938,890	1,150,909	8,037	54.00
60.00	06000	LABORATORY	243	135,521	88,677	224,441	6,981	60.00
65.00	06500	RESPIRATORY THERAPY	790	72,716	42,991	116,497	2,384	65.00
66.00	06600	PHYSICAL THERAPY	3,511	191,019	12,748	207,278	8,623	66.00
68.00	06800	SPEECH PATHOLOGY	0	5,037	640	5,677	650	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,685	4,183	7,868	19	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	529	83,868	69,203	153,600	413	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	3,942	0	3,942	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	213	30,799	15,616	46,628	470	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	20,468	0	20,468	326	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	7	90.00
91.00	09100	EMERGENCY	13,192	335,133	179,372	527,697	12,591	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)	179,595	3,871,687	3,727,422	7,778,704	116,116	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,726	0	20,726	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,028	0	2,028	63	192.00
192.01	19201	RENTED SPACE	0	474,902	92,232	567,134	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	179,595	4,369,343	3,819,654	8,368,592	116,179	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	13,779					5.01
5.02	00550	DATA PROCESSING	877	964,615				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	234	36,620	150,293			5.03
5.04	00570	ADMITTING	336	24,413	2,053	46,261		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	307	73,276	9,251	0	117,852	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,709	85,483	25,149	0	0	5.06
7.00	00700	OPERATION OF PLANT	555	0	11,896	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58	0	12,733	0	0	8.00
9.00	00900	HOUSEKEEPING	132	0	22,590	0	0	9.00
10.00	01000	DIETARY	453	36,620	10,329	0	0	10.00
11.00	01100	CAFETERIA	0	0	12,264	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	219	61,069	311	0	0	13.00
15.00	01500	PHARMACY	278	61,069	2,180	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	336	36,620	1,065	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	12,207	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,169	61,069	2,474	2,726	6,957	30.00
31.00	03100	INTENSIVE CARE UNIT	234	24,413	432	921	2,350	31.00
43.00	04300	NURSERY	0	0	157	191	487	43.00
44.00	04400	SKILLED NURSING FACILITY	0	24,413	689	634	1,619	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,710	24,413	11,670	9,020	23,018	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	36,620	39	197	502	52.00
53.00	05300	ANESTHESIOLOGY	321	0	620	873	2,229	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	701	0	4,044	12,738	32,300	54.00
60.00	06000	LABORATORY	687	73,276	10,133	6,112	15,597	60.00
65.00	06500	RESPIRATORY THERAPY	278	12,207	4,616	2,249	5,738	65.00
66.00	06600	PHYSICAL THERAPY	745	24,413	363	2,177	5,557	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	107	96	245	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2	17	44	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	612	861	2,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,001	2,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,377	8,619	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	73	0	260	58	149	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	181	463	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	1	90.00
91.00	09100	EMERGENCY	1,330	97,689	4,220	2,832	7,227	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)	12,742	805,890	150,259	46,261	117,852	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENTED SPACE	1,037	158,725	34	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	13,779	964,615	150,293	46,261	117,852	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	774,836					5.06
7.00	00700	OPERATION OF PLANT	46,817	658,041				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,991	18,739	140,890			8.00
9.00	00900	HOUSEKEEPING	19,483	35,762	7,910	264,843		9.00
10.00	01000	DIETARY	12,398	24,288	1,506	5,847	253,228	10.00
11.00	01100	CAFETERIA	18,535	10,353	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	15,426	5,797	0	657	0	13.00
15.00	01500	PHARMACY	21,037	8,757	0	4,368	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,571	12,718	0	3,048	0	16.00
17.00	01700	SOCIAL SERVICE	1,525	0	0	551	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,024	101,498	34,392	75,657	101,167	30.00
31.00	03100	INTENSIVE CARE UNIT	20,929	18,070	3,963	6,160	8,531	31.00
43.00	04300	NURSERY	6,019	2,599	1,508	6,998	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,603	18,254	9,306	9,648	36,711	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	125,939	61,482	39,144	24,503	30,641	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,566	5,335	377	1,749	0	52.00
53.00	05300	ANESTHESIOLOGY	6,372	3,476	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,223	44,074	9,922	11,212	0	54.00
60.00	06000	LABORATORY	65,056	28,172	69	8,185	0	60.00
65.00	06500	RESPIRATORY THERAPY	17,610	15,116	830	7,470	0	65.00
66.00	06600	PHYSICAL THERAPY	45,718	39,709	4,585	8,127	60,737	66.00
68.00	06800	SPEECH PATHOLOGY	3,097	1,047	0	13,338	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	194	766	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,556	17,434	0	4,061	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,068	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,551	820	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,900	6,402	50	1,734	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,153	4,255	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	30	0	0	0	0	90.00
91.00	09100	EMERGENCY	76,284	69,667	26,363	24,481	15,441	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)	758,675	554,590	139,925	217,794	253,228	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	250	4,308	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,751	421	0	0	0	192.00
192.01	19201	RENTED SPACE	14,160	98,722	965	47,049	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	774,836	658,041	140,890	264,843	253,228	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	93,932					11.00
13.00	01300	NURSING ADMINISTRATION	2,112	116,078				13.00
15.00	01500	PHARMACY	2,158	3,704	157,381			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,251	0	0	132,934		16.00
17.00	01700	SOCIAL SERVICE	232	0	0	0	14,734	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,092	27,632	33	7,850	8,912	30.00
31.00	03100	INTENSIVE CARE UNIT	3,431	5,893	22	2,652	1,269	31.00
43.00	04300	NURSERY	1,141	1,959	7	550	758	43.00
44.00	04400	SKILLED NURSING FACILITY	3,398	5,837	8	1,827	3,795	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,174	27,772	3,220	25,975	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	284	490	2	566	0	52.00
53.00	05300	ANESTHESIOLOGY	2,882	0	5,806	2,515	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,170	0	5,486	36,392	0	54.00
60.00	06000	LABORATORY	8,765	0	172	17,601	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,004	5,160	1,430	6,476	0	65.00
66.00	06600	PHYSICAL THERAPY	6,595	11,324	215	6,270	0	66.00
68.00	06800	SPEECH PATHOLOGY	425	730	0	277	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25	41	0	50	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	848	0	1,136	2,479	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,882	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	139,171	9,726	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	405	694	0	168	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	315	543	0	522	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6	10	0	1	0	90.00
91.00	09100	EMERGENCY	14,144	24,289	673	8,155	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)	93,857	116,078	157,381	132,934	14,734	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	75	0	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	93,932	116,078	157,381	132,934	14,734	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,167,201	0	1,167,201		30.00
31.00	03100	INTENSIVE CARE UNIT		225,160	0	225,160		31.00
43.00	04300	NURSERY		45,423	0	45,423		43.00
44.00	04400	SKILLED NURSING FACILITY		232,338	0	232,338		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		1,630,091	0	1,630,091		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		75,690	0	75,690		52.00
53.00	05300	ANESTHESIOLOGY		124,308	0	124,308		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,397,208	0	1,397,208		54.00
60.00	06000	LABORATORY		465,247	0	465,247		60.00
65.00	06500	RESPIRATORY THERAPY		201,065	0	201,065		65.00
66.00	06600	PHYSICAL THERAPY		432,436	0	432,436		66.00
68.00	06800	SPEECH PATHOLOGY		25,689	0	25,689		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		9,026	0	9,026		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		193,196	0	193,196		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		28,505	0	28,505		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		196,206	0	196,206		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		59,991	0	59,991		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		29,226	0	29,226		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		55	0	55		90.00
91.00	09100	EMERGENCY		913,083	0	913,083		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	7,451,144	0	7,451,144		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		25,284	0	25,284		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		4,338	0	4,338		192.00
192.01	19201	RENTED SPACE		887,826	0	887,826		192.01
194.00	07950	FUND DEVELOPMENT		0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	8,368,592	0	8,368,592		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	271,535					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,000,450				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,243	12,349	31,818,710			4.00
5.01	00540	NONPATIENT TELEPHONES	827	371	0	943		5.01
5.02	00550	DATA PROCESSING	2,961	716,816	976,845	60	26,710	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	6,982	4	297,259	16	1,014	5.03
5.04	00570	ADMITTING	1,019	583	635,504	23	676	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,988	411	686,366	21	2,029	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	21,219	244,024	2,849,930	117	2,367	5.06
7.00	00700	OPERATION OF PLANT	33,575	42,511	986,628	38	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,602	8,962	223,748	4	0	8.00
9.00	00900	HOUSEKEEPING	10,691	2,912	883,923	9	0	9.00
10.00	01000	DIETARY	7,261	34,412	312,551	31	1,014	10.00
11.00	01100	CAFETERIA	3,095	0	815,792	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,733	0	712,411	15	1,691	13.00
15.00	01500	PHARMACY	2,618	3,649	750,302	19	1,691	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,802	0	587,743	23	1,014	16.00
17.00	01700	SOCIAL SERVICE	0	0	59,925	0	338	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,342	87,164	3,794,403	80	1,691	30.00
31.00	03100	INTENSIVE CARE UNIT	5,402	24,424	1,048,663	16	676	31.00
43.00	04300	NURSERY	777	0	325,540	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,457	7,883	753,522	0	676	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,380	622,410	3,875,054	117	676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	0	81,386	0	1,014	52.00
53.00	05300	ANESTHESIOLOGY	1,039	56,828	50,824	22	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,176	737,524	2,201,377	48	0	54.00
60.00	06000	LABORATORY	8,422	69,658	1,912,138	47	2,029	60.00
65.00	06500	RESPIRATORY THERAPY	4,519	33,771	652,926	19	338	65.00
66.00	06600	PHYSICAL THERAPY	11,871	10,014	2,361,755	51	676	66.00
68.00	06800	SPEECH PATHOLOGY	313	503	177,909	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	229	3,286	5,205	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,212	54,361	113,245	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	245	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,914	12,267	128,803	5	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,272	0	89,216	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,840	0	0	90.00
91.00	09100	EMERGENCY	20,827	140,902	3,448,614	91	2,705	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)	240,608	2,927,999	31,801,347	872	22,315	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126	0	17,363	0	0	192.00
192.01	19201	RENTED SPACE	29,513	72,451	0	71	4,395	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	4,369,343	3,819,654	10,730,007	58,977	3,669,281	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.091270	1.273027	0.337223	62.541888	137.374803	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			116,179	13,779	964,615	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003651	14.611877	36.114377	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,134,987					5.03
5.04	00570	ADMITTING	15,503	252,115,935				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	69,865	0	252,115,935			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	189,913	0	0	-9,562,680	64,325,226	5.06
7.00	00700	OPERATION OF PLANT	89,836	0	0	0	3,886,528	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	96,160	0	0	0	580,360	8.00
9.00	00900	HOUSEKEEPING	170,599	0	0	0	1,617,407	9.00
10.00	01000	DIETARY	78,006	0	0	0	1,029,197	10.00
11.00	01100	CAFETERIA	92,617	0	0	0	1,538,649	11.00
13.00	01300	NURSING ADMINISTRATION	2,348	0	0	0	1,280,621	13.00
15.00	01500	PHARMACY	16,466	0	0	0	1,746,349	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,043	0	0	0	1,043,601	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	126,566	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,682	14,896,389	14,896,389	0	6,394,161	30.00
31.00	03100	INTENSIVE CARE UNIT	3,260	5,031,634	5,031,634	0	1,737,410	31.00
43.00	04300	NURSERY	1,185	1,043,290	1,043,290	0	499,659	43.00
44.00	04400	SKILLED NURSING FACILITY	5,201	3,466,808	3,466,808	0	1,295,322	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	88,127	49,289,365	49,289,365	0	10,457,020	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	296	1,073,989	1,073,989	0	296,066	52.00
53.00	05300	ANESTHESIOLOGY	4,681	4,771,972	4,771,972	0	528,951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,537	68,926,294	68,926,294	0	6,078,577	54.00
60.00	06000	LABORATORY	76,523	33,399,117	33,399,117	0	5,400,593	60.00
65.00	06500	RESPIRATORY THERAPY	34,859	12,287,893	12,287,893	0	1,461,915	65.00
66.00	06600	PHYSICAL THERAPY	2,742	11,898,362	11,898,362	0	3,795,297	66.00
68.00	06800	SPEECH PATHOLOGY	810	524,741	524,741	0	257,068	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18	93,984	93,984	0	16,067	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,620	4,703,160	4,703,160	0	793,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,468,998	5,468,998	0	1,832,015	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,455,210	18,455,210	0	2,536,172	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,962	318,618	318,618	0	240,716	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	990,672	990,672	0	178,771	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,091	1,091	0	2,512	90.00
91.00	09100	EMERGENCY	31,871	15,474,348	15,474,348	0	6,332,749	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)	1,134,730	252,115,935	252,115,935	-9,562,680	62,983,650	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	20,726	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	145,329	192.00
192.01	19201	RENTED SPACE	257	0	0	0	1,175,521	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	806,905	992,828	1,894,469		9,562,680	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.710938	0.003938	0.007514		0.148661	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	150,293	46,261	117,852		774,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.132418	0.000183	0.000467		0.012046	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	196,721					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,602	1,048,284				8.00
9.00	00900	HOUSEKEEPING	10,691	58,854	49,958			9.00
10.00	01000	DIETARY	7,261	11,205	1,103	74,800		10.00
11.00	01100	CAFETERIA	3,095	0	0	0	45,278	11.00
13.00	01300	NURSING ADMINISTRATION	1,733	0	124	0	1,018	13.00
15.00	01500	PHARMACY	2,618	0	824	0	1,040	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,802	0	575	0	1,567	16.00
17.00	01700	SOCIAL SERVICE	0	0	104	0	112	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,342	255,894	14,271	29,883	7,757	30.00
31.00	03100	INTENSIVE CARE UNIT	5,402	29,488	1,162	2,520	1,654	31.00
43.00	04300	NURSERY	777	11,222	1,320	0	550	43.00
44.00	04400	SKILLED NURSING FACILITY	5,457	69,241	1,820	10,844	1,638	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,380	291,244	4,622	9,051	7,796	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	2,805	330	0	137	52.00
53.00	05300	ANESTHESIOLOGY	1,039	0	0	0	1,389	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,176	73,821	2,115	0	3,938	54.00
60.00	06000	LABORATORY	8,422	517	1,544	0	4,225	60.00
65.00	06500	RESPIRATORY THERAPY	4,519	6,177	1,409	0	1,448	65.00
66.00	06600	PHYSICAL THERAPY	11,871	34,114	1,533	17,941	3,179	66.00
68.00	06800	SPEECH PATHOLOGY	313	0	2,516	0	205	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	229	0	0	0	12	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,212	0	766	0	409	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	245	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,914	370	327	0	195	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,272	0	0	0	152	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	3	90.00
91.00	09100	EMERGENCY	20,827	196,155	4,618	4,561	6,818	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)	165,794	1,041,107	41,083	74,800	45,242	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126	0	0	0	36	192.00
192.01	19201	RENTED SPACE	29,513	7,177	8,875	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	4,464,303	793,766	2,145,034	1,402,819	1,837,623	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.693576	0.757205	42.936747	18.754265	40.585339	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	658,041	140,890	264,843	253,228	93,932	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.345047	0.134401	5.301313	3.385401	2.074562	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 2:04 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	15.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	677,736					13.00
15.00	01500	PHARMACY	21,625	2,624,559				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	252,115,935			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	14,052		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	161,335	547	14,896,389	8,500		30.00
31.00	03100	INTENSIVE CARE UNIT	34,408	360	5,031,634	1,210		31.00
43.00	04300	NURSERY	11,436	119	1,043,290	723		43.00
44.00	04400	SKILLED NURSING FACILITY	34,081	129	3,466,808	3,619		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	162,154	53,694	49,289,365	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,859	30	1,073,989	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	96,831	4,771,972	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	91,492	68,926,294	0	0	54.00
60.00	06000	LABORATORY	0	2,863	33,399,117	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	30,125	23,845	12,287,893	0	0	65.00
66.00	06600	PHYSICAL THERAPY	66,119	3,587	11,898,362	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	4,261	0	524,741	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	241	0	93,984	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,945	4,703,160	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,468,998	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,320,881	18,455,210	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,051	0	318,618	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,168	8	990,672	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	58	0	1,091	0	0	90.00
91.00	09100	EMERGENCY	141,815	11,228	15,474,348	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)	677,736	2,624,559	252,115,935	14,052	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,556,967	2,192,643	1,373,311	154,392	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.297306	0.835433	0.005447	10.987190	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	116,078	157,381	132,934	14,734	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.171273	0.059965	0.000527	1.048534	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,260,683		10,260,683	0	10,260,683	30.00
31.00	03100	INTENSIVE CARE UNIT	2,424,944		2,424,944	0	2,424,944	31.00
43.00	04300	NURSERY	719,066		719,066	0	719,066	43.00
44.00	04400	SKILLED NURSING FACILITY	2,149,199		2,149,199	0	2,149,199	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,019,699		14,019,699	0	14,019,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	410,571		410,571	0	410,571	52.00
53.00	05300	ANESTHESIOLOGY	794,426		794,426	0	794,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,039,680		8,039,680	0	8,039,680	54.00
60.00	06000	LABORATORY	6,817,051		6,817,051	0	6,817,051	60.00
65.00	06500	RESPIRATORY THERAPY	2,061,799	0	2,061,799	0	2,061,799	65.00
66.00	06600	PHYSICAL THERAPY	5,405,752	0	5,405,752	26,219	5,431,971	66.00
68.00	06800	SPEECH PATHOLOGY	431,383	0	431,383	0	431,383	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,206		25,206	0	25,206	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,120,481		1,120,481	0	1,120,481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,134,154		2,134,154	0	2,134,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,958,228		4,958,228	0	4,958,228	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	353,213		353,213	0	353,213	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	253,063		253,063	0	253,063	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,146		3,146	0	3,146	90.00
91.00	09100	EMERGENCY	8,875,343		8,875,343	28,114	8,903,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	858,372		858,372		858,372	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	72,115,459	0	72,115,459	54,333	72,169,792	200.00
201.00		Less Observation Beds	858,372		858,372		858,372	201.00
202.00		Total (see instructions)	71,257,087	0	71,257,087	54,333	71,311,420	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 2:04 pm

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	13,961,969		13,961,969			30.00
31.00	03100	INTENSIVE CARE UNIT	5,031,634		5,031,634			31.00
43.00	04300	NURSERY	1,043,290		1,043,290			43.00
44.00	04400	SKILLED NURSING FACILITY	3,466,808		3,466,808			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,839,422	37,449,943	49,289,365	0.284437	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	832,760	241,229	1,073,989	0.382286	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,257,775	3,514,197	4,771,972	0.166478	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,619,988	63,306,306	68,926,294	0.116642	0.000000	54.00
60.00	06000	LABORATORY	10,036,146	23,362,971	33,399,117	0.204109	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,100,988	7,186,905	12,287,893	0.167791	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,115,827	8,782,535	11,898,362	0.454327	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	100,982	423,759	524,741	0.822087	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	93,984	93,984	0.268195	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,860,394	1,842,766	4,703,160	0.238240	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,398,378	2,070,620	5,468,998	0.390228	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,872,736	10,582,474	18,455,210	0.268663	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	824	317,794	318,618	1.108578	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,199	988,473	990,672	0.255446	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,091	1,091	2.883593	0.000000	90.00
91.00	09100	EMERGENCY	2,077,139	13,397,209	15,474,348	0.573552	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	74,061	860,359	934,420	0.918615	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	77,693,320	174,422,615	252,115,935			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	77,693,320	174,422,615	252,115,935			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 2:04 pm

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
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.284437		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.382286		52.00
53.00	05300	ANESTHESIOLOGY	0.166478		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116642		54.00
60.00	06000	LABORATORY	0.204109		60.00
65.00	06500	RESPIRATORY THERAPY	0.167791		65.00
66.00	06600	PHYSICAL THERAPY	0.456531		66.00
68.00	06800	SPEECH PATHOLOGY	0.822087		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.268195		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.238240		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.390228		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.268663		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	1.108578		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.255446		76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2.883593		90.00
91.00	09100	EMERGENCY	0.575369		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.918615		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: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 2:04 pm

Title XIX | Hospital

		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	10,260,683		10,260,683	0	10,260,683	30.00
31.00	03100	INTENSIVE CARE UNIT	2,424,944		2,424,944	0	2,424,944	31.00
43.00	04300	NURSERY	719,066		719,066	0	719,066	43.00
44.00	04400	SKILLED NURSING FACILITY	2,149,199		2,149,199	0	2,149,199	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,019,699		14,019,699	0	14,019,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	410,571		410,571	0	410,571	52.00
53.00	05300	ANESTHESIOLOGY	794,426		794,426	0	794,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,039,680		8,039,680	0	8,039,680	54.00
60.00	06000	LABORATORY	6,817,051		6,817,051	0	6,817,051	60.00
65.00	06500	RESPIRATORY THERAPY	2,061,799	0	2,061,799	0	2,061,799	65.00
66.00	06600	PHYSICAL THERAPY	5,405,752	0	5,405,752	26,219	5,431,971	66.00
68.00	06800	SPEECH PATHOLOGY	431,383	0	431,383	0	431,383	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	25,206		25,206	0	25,206	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,120,481		1,120,481	0	1,120,481	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,134,154		2,134,154	0	2,134,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,958,228		4,958,228	0	4,958,228	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	353,213		353,213	0	353,213	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	253,063		253,063	0	253,063	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,146		3,146	0	3,146	90.00
91.00	09100	EMERGENCY	8,875,343		8,875,343	28,114	8,903,457	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	858,372		858,372		858,372	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	72,115,459	0	72,115,459	54,333	72,169,792	200.00
201.00		Less Observation Beds	858,372		858,372		858,372	201.00
202.00		Total (see instructions)	71,257,087	0	71,257,087	54,333	71,311,420	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 2:04 pm

Title XIX | Hospital

		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	13,961,969		13,961,969			30.00
31.00	03100	INTENSIVE CARE UNIT	5,031,634		5,031,634			31.00
43.00	04300	NURSERY	1,043,290		1,043,290			43.00
44.00	04400	SKILLED NURSING FACILITY	3,466,808		3,466,808			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,839,422	37,449,943	49,289,365	0.284437	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	832,760	241,229	1,073,989	0.382286	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,257,775	3,514,197	4,771,972	0.166478	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,619,988	63,306,306	68,926,294	0.116642	0.000000	54.00
60.00	06000	LABORATORY	10,036,146	23,362,971	33,399,117	0.204109	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,100,988	7,186,905	12,287,893	0.167791	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,115,827	8,782,535	11,898,362	0.454327	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	100,982	423,759	524,741	0.822087	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	93,984	93,984	0.268195	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,860,394	1,842,766	4,703,160	0.238240	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,398,378	2,070,620	5,468,998	0.390228	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,872,736	10,582,474	18,455,210	0.268663	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	824	317,794	318,618	1.108578	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,199	988,473	990,672	0.255446	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,091	1,091	2.883593	0.000000	90.00
91.00	09100	EMERGENCY	2,077,139	13,397,209	15,474,348	0.573552	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	74,061	860,359	934,420	0.918615	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	77,693,320	174,422,615	252,115,935			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	77,693,320	174,422,615	252,115,935			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 2:04 pm

Title XIX | Hospital

		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
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
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
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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 SERVICE COST CENTERS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
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: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part I Date/Time Prepared: 2/25/2015 2:04 pm

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	1,167,201	0	1,167,201	9,276	125.83	30.00
31.00	INTENSIVE CARE UNIT	225,160		225,160	1,210	186.08	31.00
43.00	NURSERY	45,423		45,423	723	62.83	43.00
44.00	SKILLED NURSING FACILITY	232,338		232,338	3,619	64.20	44.00
200.00	Total (lines 30-199)	1,670,122		1,670,122	14,828		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	4,932	620,594	30.00
31.00	INTENSIVE CARE UNIT	803	149,422	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	2,956	189,775	44.00
200.00	Total (lines 30-199)	8,691	959,791	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/25/2015 2:04 pm

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	1,630,091	49,289,365	0.033072	6,021,220	199,134	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	75,690	1,073,989	0.070476	10,062	709	52.00
53.00	05300	ANESTHESIOLOGY	124,308	4,771,972	0.026050	466,225	12,145	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,397,208	68,926,294	0.020271	5,110,704	103,599	54.00
60.00	06000	LABORATORY	465,247	33,399,117	0.013930	6,185,727	86,167	60.00
65.00	06500	RESPIRATORY THERAPY	201,065	12,287,893	0.016363	2,898,892	47,435	65.00
66.00	06600	PHYSICAL THERAPY	432,436	11,898,362	0.036344	1,155,876	42,009	66.00
68.00	06800	SPEECH PATHOLOGY	25,689	524,741	0.048956	62,291	3,050	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,026	93,984	0.096038	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	193,196	4,703,160	0.041078	777,250	31,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,505	5,468,998	0.005212	1,845,453	9,619	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	196,206	18,455,210	0.010631	5,514,375	58,623	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	59,991	318,618	0.188285	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	29,226	990,672	0.029501	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55	1,091	0.050412	0	0	90.00
91.00	09100	EMERGENCY	913,083	15,474,348	0.059006	1,328,908	78,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	97,644	934,420	0.104497	61,308	6,407	92.00
200.00		Total (lines 50-199)	5,878,666	228,612,234		31,438,291	679,239	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part III Date/Time Prepared: 2/25/2015 2:04 pm

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
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
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	9,276	0.00	4,932	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,210	0.00	803	0		31.00
43.00	04300	NURSERY	723	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	3,619	0.00	2,956	0		44.00
200.00		Total (lines 30-199)	14,828		8,691	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/25/2015 2:04 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
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
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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 SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/25/2015 2:04 pm

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	49,289,365	0.000000	0.000000	6,021,220	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,073,989	0.000000	0.000000	10,062	52.00
53.00	05300	ANESTHESIOLOGY	0	4,771,972	0.000000	0.000000	466,225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68,926,294	0.000000	0.000000	5,110,704	54.00
60.00	06000	LABORATORY	0	33,399,117	0.000000	0.000000	6,185,727	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,287,893	0.000000	0.000000	2,898,892	65.00
66.00	06600	PHYSICAL THERAPY	0	11,898,362	0.000000	0.000000	1,155,876	66.00
68.00	06800	SPEECH PATHOLOGY	0	524,741	0.000000	0.000000	62,291	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	93,984	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,703,160	0.000000	0.000000	777,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,468,998	0.000000	0.000000	1,845,453	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,455,210	0.000000	0.000000	5,514,375	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	318,618	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	990,672	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,091	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	15,474,348	0.000000	0.000000	1,328,908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	934,420	0.000000	0.000000	61,308	92.00
200.00		Total (lines 50-199)	0	228,612,234			31,438,291	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,590,986	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	883,974	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,936,438	0		54.00
60.00	06000	LABORATORY	0	4,154,366	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,454,589	0		65.00
66.00	06600	PHYSICAL THERAPY	0	723,149	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,508	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	852,865	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	682,632	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,914,997	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	153,924	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	458,571	0		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	3,511,923	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	388,098	0		92.00
200.00		Total (lines 50-199)	0	49,730,020	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/25/2015 2:04 pm

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	0.284437	11,590,986	3,783	0	3,296,905	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.382286	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.166478	883,974	0	0	147,162	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116642	19,936,438	0	0	2,325,426	54.00
60.00	06000	LABORATORY	0.204109	4,154,366	0	0	847,943	60.00
65.00	06500	RESPIRATORY THERAPY	0.167791	2,454,589	0	0	411,858	65.00
66.00	06600	PHYSICAL THERAPY	0.454327	723,149	5,283	0	328,546	66.00
68.00	06800	SPEECH PATHOLOGY	0.822087	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.268195	23,508	0	0	6,305	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.238240	852,865	58	0	203,187	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.390228	682,632	0	0	266,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.268663	3,914,997	0	96,228	1,051,815	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.108578	153,924	0	0	170,637	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.255446	458,571	0	0	117,140	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.883593	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.573552	3,511,923	0	0	2,014,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.918615	388,098	0	0	356,513	92.00
200.00		Subtotal (see instructions)		49,730,020	9,124	96,228	11,544,089	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		49,730,020	9,124	96,228	11,544,089	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/25/2015 2:04 pm

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	1,076	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
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	2,400	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,853		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
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)	3,490	25,853		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,490	25,853		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Skilled Nursing Facility | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
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
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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 SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Skilled Nursing Facility | 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	49,289,365	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,073,989	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,771,972	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	68,926,294	0.000000	0.000000	97,446	54.00
60.00	06000	LABORATORY	0	33,399,117	0.000000	0.000000	507,310	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,287,893	0.000000	0.000000	468,586	65.00
66.00	06600	PHYSICAL THERAPY	0	11,898,362	0.000000	0.000000	1,191,663	66.00
68.00	06800	SPEECH PATHOLOGY	0	524,741	0.000000	0.000000	21,930	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	93,984	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,703,160	0.000000	0.000000	204,485	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,468,998	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,455,210	0.000000	0.000000	811,137	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	318,618	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	990,672	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,091	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	15,474,348	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	934,420	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	228,612,234			3,302,557	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140058 Component CCN: 145951	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 2:04 pm
	Title XVIII	Skilled Nursing Facility	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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
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
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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 SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Skilled Nursing Facility | 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	0.284437	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.382286	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.166478	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116642	0	0	0	0	54.00
60.00	06000	LABORATORY	0.204109	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.167791	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.454327	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.822087	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.268195	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.238240	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.390228	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.268663	0	0	1,057	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.108578	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.255446	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.883593	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.573552	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.918615	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	1,057	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	1,057	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Skilled Nursing Facility | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
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
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	284		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
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)	0	284		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	284		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 2:04 pm

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)	9,276	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,276	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)	8,500	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)	4,932	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)	10,260,683	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)	10,260,683	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)	10,260,683	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)	1,106.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,455,532	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)	5,455,532	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,424,944	1,210	2,004.09	803	1,609,284	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,925,875	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,990,691	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)	770,016	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	679,239	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,449,255	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,541,436	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)	776	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,106.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	858,372	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 2:04 pm

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	1,167,201	10,260,683	0.113755	858,372	97,644	90.00
91.00	Nursing School cost	0	10,260,683	0.000000	858,372	0	91.00
92.00	Allied health cost	0	10,260,683	0.000000	858,372	0	92.00
93.00	All other Medical Education	0	10,260,683	0.000000	858,372	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140058 Component CCN: 145951	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 2/25/2015 2:04 pm
	Title XVIII	Skilled Nursing Facility	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)	3,619	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,619	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)	3,619	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,956	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)	2,149,199	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)	2,149,199	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)	2,149,199	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,149,199	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	593.87	71.00
72.00	Program routine service cost (line 9 x line 71)	1,755,480	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,755,480	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,755,480	83.00
84.00	Program inpatient ancillary services (see instructions)	1,019,610	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,775,090	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: 140058 | Component CCN: 145951 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Skilled Nursing Facility | 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/25/2015 2:04 pm

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		7,667,647		30.00
31.00	03100	INTENSIVE CARE UNIT		3,347,202		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.284437	6,021,220	1,712,658	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.382286	10,062	3,847	52.00
53.00	05300	ANESTHESIOLOGY	0.166478	466,225	77,616	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116642	5,110,704	596,123	54.00
60.00	06000	LABORATORY	0.204109	6,185,727	1,262,563	60.00
65.00	06500	RESPIRATORY THERAPY	0.167791	2,898,892	486,408	65.00
66.00	06600	PHYSICAL THERAPY	0.456531	1,155,876	527,693	66.00
68.00	06800	SPEECH PATHOLOGY	0.822087	62,291	51,209	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.268195	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.238240	777,250	185,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.390228	1,845,453	720,147	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.268663	5,514,375	1,481,509	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.108578	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.255446	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.883593	0	0	90.00
91.00	09100	EMERGENCY	0.575369	1,328,908	764,612	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.918615	61,308	56,318	92.00
200.00		Total (sum of lines 50-94 and 96-98)		31,438,291	7,925,875	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)		31,438,291		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140058 | Component CCN: 145951 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Skilled Nursing Facility | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.284437	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.382286	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.166478	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.116642	97,446	11,366	54.00
60.00	06000	LABORATORY	0.204109	507,310	103,547	60.00
65.00	06500	RESPIRATORY THERAPY	0.167791	468,586	78,625	65.00
66.00	06600	PHYSICAL THERAPY	0.454327	1,191,663	541,405	66.00
68.00	06800	SPEECH PATHOLOGY	0.822087	21,930	18,028	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.268195	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.238240	204,485	48,717	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.390228	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.268663	811,137	217,922	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.108578	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.255446	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.883593	0	0	90.00
91.00	09100	EMERGENCY	0.573552	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.918615	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,302,557	1,019,610	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)		3,302,557		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E Part A Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		9,258,558			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		0			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		0			1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0			1.03
2.00	Outlier payments for discharges. (see instructions)		180,023			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		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		90.87			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)		0.00			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)		0.00			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) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 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)		0.00			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)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			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)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			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.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			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		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
	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)		0.00			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
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.44			30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.85			31.00
32.00	Sum of lines 30 and 31		22.29			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E Part A Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
33.00	Allowable disproportionate share percentage (see instructions)		7.60			33.00
34.00	Disproportionate share adjustment (see instructions)		175,913			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		9,046,380,143	35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000048587	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		439,536	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		439,536	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		439,536			36.00
	Additional payment for high percentage of ESRD beneficiary discharges					
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	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	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	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)		10,054,030			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		11,513,191			48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		11,513,191			49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		758,772			50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part 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, Part III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		12,271,963			59.00
60.00	Primary payer payments		10,879			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		12,261,084			61.00
62.00	Deductibles billed to program beneficiaries		1,377,664			62.00
63.00	Coinsurance billed to program beneficiaries		12,464			63.00
64.00	Allowable bad debts (see instructions)		406,369			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		264,140			65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E Part A Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Hospital | PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		390,312			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		11,135,096			67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (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
70.92	Bundled Model 1 discount amount		0			70.92
70.93	HVBP incentive payment (see instructions)		-45,501			70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-13,887			70.94
70.95	Recovery of accelerated depreciation		0			70.95
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
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,075,708			71.00
71.01	Sequestration adjustment (see instructions)		221,514			71.01
72.00	Interim payments		10,915,468			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		-61,274			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0			90.00
91.00	Capital outlier from Worksheet L, Part 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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140058	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/25/2015 2:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	29,343	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,544,089	2.00
3.00	PPS payments	8,759,129	3.00
4.00	Outlier payment (see instructions)	40,363	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 Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	29,343	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	105,352	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	105,352	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)	105,352	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	76,009	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)	29,343	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)	8,799,492	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	1,795	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,076,725	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	6,750,315	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	6,750,315	30.00
31.00	Primary payer payments	324	31.00
32.00	Subtotal (line 30 minus line 31)	6,749,991	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	494,609	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	321,496	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	468,448	36.00
37.00	Subtotal (see instructions)	7,071,487	37.00
38.00	MSP-LCC reconciliation amount from PS&R	4	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
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)	7,071,483	40.00
40.01	Sequestration adjustment (see instructions)	141,430	40.01
41.00	Interim payments	6,919,732	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	10,321	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: 140058 Component CCN: 145951	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/25/2015 2:04 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	284	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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 Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	284	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,057	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	1,057	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)	1,057	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	773	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)	284	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	284	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	284	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	284	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet 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)	284	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
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)	284	40.00
40.01	Sequestration adjustment (see instructions)	6	40.01
41.00	Interim payments	238	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	40	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 2/25/2015 2:04 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,970,995		6,922,091	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	05/16/2014	55,527	05/16/2014	2,359	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)		-55,527		-2,359	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)		10,915,468		6,919,732	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		0		10,321	6.01
6.02	SETTLEMENT TO PROGRAM		61,274		0	6.02
7.00	Total Medicare program liability (see instructions)		10,854,194		6,930,053	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: 140058 Component CCN: 145951	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part I Date/Time Prepared: 2/25/2015 2:04 pm
Title XVIII	Skilled Nursing Facility	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		944,022		238	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)		944,022		238	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		0		40	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		944,022		278	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: 140058	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 2/25/2015 2:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	2,943	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	5,735	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	463	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	9,710	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	252,115,935	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	8,168,565	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,167,075	8.00
9.00	Sequestration adjustment amount (see instructions)	23,342	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,143,733	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	1,143,733	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140058 Component CCN: 145951	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VI Date/Time Prepared: 2/25/2015 2:04 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,011,756	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,011,756	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	48,468	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	963,288	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	963,288	15.00
15.01	Sequestration adjustment (see instructions)	19,266	15.01
16.00	Interim payments	944,022	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G | Date/Time Prepared: 2/25/2015 2:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,196,115	0	0	0	1.00
2.00	Temporary investments	9,199,618	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	41,979,366	0	0	0	4.00
5.00	Other receivable	6,969,532	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-31,088,199	0	0	0	6.00
7.00	Inventory	766,180	0	0	0	7.00
8.00	Prepaid expenses	1,458,611	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	31,078,443	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	65,559,666	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	975,458	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-21,323	0	0	0	14.00
15.00	Buildings	10,230,628	0	0	0	15.00
16.00	Accumulated depreciation	-216,421	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	9,051,059	0	0	0	19.00
20.00	Accumulated depreciation	-1,626,595	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)	18,392,806	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	63,510,161	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	3,541,179	0	0	0	33.00
34.00	Other assets	23,431,492	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	90,482,832	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	174,435,304	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,449,991	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,581,673	0	0	0	38.00
39.00	Payroll taxes payable	2,873,917	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,564,402	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	0	0	0	0	43.00
44.00	Other current liabilities	11,851,580	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,321,563	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	27,191,172	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,445,633	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	30,636,805	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	50,958,368	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	123,476,936				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)	123,476,936	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	174,435,304	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 2/25/2015 2:04 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		111,591,662		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,833,113				2.00
3.00	Total (sum of line 1 and line 2)		121,424,775		0		3.00
4.00	RESTRICTED ASSETS	1,975,054		0		0	4.00
5.00	CHANGE IN VALUE OF SWAPS	77,107		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)		2,052,161		0		10.00
11.00	Subtotal (line 3 plus line 10)		123,476,936		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		123,476,936		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	RESTRICTED ASSETS		0			4.00
5.00	CHANGE IN VALUE OF SWAPS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140058 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2015 2:04 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,332,424		15,332,424	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	3,466,808		3,466,808	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)	18,799,232		18,799,232	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,045,549		5,045,549	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,045,549		5,045,549	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	23,844,781		23,844,781	17.00
18.00	Ancillary services	53,181,536	164,060,869	217,242,405	18.00
19.00	Outpatient services	2,178,428	14,605,584	16,784,012	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	PHYSICIAN PROFESSIONAL CHARGES	0	120,665	120,665	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	79,204,745	178,787,118	257,991,863	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		79,917,630		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)		79,917,630		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140058	Period: From 10/01/2013 To 09/30/2014	Worksheet G-3 Date/Time Prepared: 2/25/2015 2:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	257,991,863	1.00
2.00	Less contractual allowances and discounts on patients' accounts	175,466,767	2.00
3.00	Net patient revenues (line 1 minus line 2)	82,525,096	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	79,917,630	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,607,466	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	314,640	6.00
7.00	Income from investments	4,291,364	7.00
8.00	Revenues from telephone and other miscellaneous communication services	8,630	8.00
9.00	Revenue from television and radio service	16,223	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	459,609	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	33,931	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	4,628	21.00
22.00	Rental of hospital space	306,341	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	139,557	24.00
24.01	LIFELINE REVENUE	153,843	24.01
24.02	EHR INCENTIVE PAYMENTS	1,496,881	24.02
25.00	Total other income (sum of lines 6-24)	7,225,647	25.00
26.00	Total (line 5 plus line 25)	9,833,113	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)	9,833,113	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140058	Period: From 10/01/2013 To 09/30/2014	Worksheet L Parts I-III Date/Time Prepared: 2/25/2015 2:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	735,202	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	23,570	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)	27.20	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	758,772	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