

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: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/26/2015 11:57 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: _____ Time: _____
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No. _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE SAINT JOSEPH HOSP-CHICAGO (140224) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	1,347,731	-241,869	262,945	6,888,491	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	45,433	556		297,305	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	540	-493		0	7.00
200.00 Total	0	1,393,704	-241,806	262,945	7,185,796	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 11:57 am			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00 Street: 2900 NORTH LAKE SHORE DRIVE		PO Box:		Zip Code: 60657		County: COOK						
2.00 City: CHICAGO		State: IL										
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
								V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:												
3.00 Hospital		PRESENCE SAINT JOSEPH HOSP-CHICAGO		140224	16974	1	07/01/1966	N	P	O	3.00	
4.00 Subprovider - IPF		PSYCH UNIT		14S224	16974	4	07/01/1966	N	P	O	4.00	
5.00 Subprovider - IRF		REHAB UNIT		14T224	16974	5	07/01/1985	N	P	O	5.00	
6.00 Subprovider - (Other)											6.00	
7.00 Swing Beds - SNF											7.00	
8.00 Swing Beds - NF											8.00	
9.00 Hospital-Based SNF		SKILLED CARE		145568	16974		01/28/1987	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)							01/01/2014		12/31/2014		20.00	
21.00 Type of Control (see instructions)									1		21.00	
Inpatient PPS Information												
22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.							Y		N		22.00	
22.01 Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							Y		Y		22.01	
22.02 Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.							N		N		22.02	
22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.							N		N		22.03	
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.									2		N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				6,934	3,299	0	0	431	1,016		24.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.				143	80	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 11:57 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	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)	Y			3.50	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

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				Y	63.00	
				Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			8.12	29.85	0.213853	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.57	16.24	0.033908	65.00
65.01		INTERNAL MEDICINE	1400	2.88	62.28	0.044199	65.01

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	9.23	33.94	0.213806		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.97	17.01	0.053949 67.00	
67.01		INTERNAL MEDICINE	1400	0.50	74.45	0.006671 67.01	
				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.			Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			N	0		71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			N	0		76.00
				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N	81.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 11:57 am	
		1.00	2.00				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H082			140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: PRESENCE HEALTH	Contractor's Name: NGS		Contractor's Number: 00131		141.00	
142.00	Street: 200 S. WACKER DRIVE	PO Box:				142.00	
143.00	City: CHI CAGO	State: IL		Zip Code: 60606		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y		145.00	
						1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	N	157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00
161.00	CMHC		N	N	N	N	161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
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	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.75	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 11:57 am	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2013	09/30/2014	170.00
			1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/26/2015 11:57 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/13/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/26/2015 11:57 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SANDRA		COSLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815 806 2327		SANDRA.COSLER@PRESENCEHEALTH.ORG	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/13/2015	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SYSTEM DIRECTOR OF REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part IX Date/Time Prepared: 5/26/2015 11:57 am	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	3.00
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140224

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2015 11:57 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	235	78,755	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)		235	78,755	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	19	6,935	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)		254	85,690	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	34	12,410		0	16.00
17.00 SUBPROVIDER - IRF	41.00	23	8,395		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	28	10,220		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)		339				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)		1	365			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: 140224

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2015 11:57 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	18,148	1,459	41,067			1.00
2.00 HMO and other (see instructions)	2,683	5,750				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	18,148	1,459	41,067			7.00
8.00 INTENSIVE CARE UNIT	1,835	157	3,177			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		2,506	4,863			13.00
14.00 Total (see instructions)	19,983	4,122	49,107	119.96	1,241.12	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	1,808	8,826	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	1,597	223	2,477	0.00	19.15	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	4,506	0	6,060	0.00	29.37	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)				119.96	1,289.64	27.00
28.00 Observation Bed Days		242	2,043			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			189			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140224

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2015 11:57 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	3,576	1,237	9,321	1.00
2.00 HMO and other (see instructions)			478	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	3,576	1,237	9,321	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	340	1,432	16.00
17.00 SUBPROVIDER - IRF	0.00	0	134	17	203	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: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet S-3 Part II Date/Time Prepared: 5/26/2015 11:57 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	75,662,766	0	75,662,766	2,690,052.85	28.13	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		798,814	0	798,814	5,879.80	135.86	4.00
4.01	Physicians - Part A - Teaching		3,069,453	0	3,069,453	42,969.28	71.43	4.01
5.00	Physician-Part B		51,494	0	51,494	457.59	112.53	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	6,968,525	6,968,525	301,640.00	23.10	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	1,532,288	0	1,532,288	61,247.02	25.02	9.00
10.00	Excluded area salaries (see instructions)		7,920,044	0	7,920,044	159,039.69	49.80	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		4,099,172	0	4,099,172	104,343.00	39.29	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		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		10,495,497	0	10,495,497	218,940.00	47.94	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)		14,965,130	0	14,965,130			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,313,630	0	1,313,630			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		86,280	0	86,280			22.00
22.01	Physician Part A - Teaching		433,584	0	433,584			22.01
23.00	Physician Part B		5,955	0	5,955			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		1,544,153	0	1,544,153			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	38,386	0	38,386	4,146.75	9.26	26.00
27.00	Administrative & General	5.00	5,902,452	108,750	6,011,202	230,404.21	26.09	27.00
28.00	Administrative & General under contract (see inst.)		207,031	0	207,031	2,546.99	81.28	28.00
29.00	Maintenance & Repairs	6.00	418,459	0	418,459	12,663.94	33.04	29.00
30.00	Operation of Plant	7.00	677,970	0	677,970	17,840.13	38.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,253,079	0	1,253,079	100,173.07	12.51	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,512,701	-628,802	883,899	62,651.71	14.11	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	628,802	628,802	44,198.00	14.23	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,792,670	0	1,792,670	39,275.12	45.64	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	2,544,122	0	2,544,122	64,350.51	39.54	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140224

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

Worksheet S-3
Part II
Date/Time Prepared:
5/26/2015 11:57 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	16.00 753,046	0	753,046	33,756.18	22.31	41.00
42.00	Social Service	17.00 1,396,369	0	1,396,369	35,800.40	39.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140224

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

Worksheet S-3
Part III
Date/Time Prepared:
5/26/2015 11:57 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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)	72,748,850	-6,968,525	65,780,325	2,347,532.97	28.02	1.00
2.00	Excluded area salaries (see instructions)	9,452,332	0	9,452,332	220,286.71	42.91	2.00
3.00	Subtotal salaries (line 1 minus line 2)	63,296,518	-6,968,525	56,327,993	2,127,246.26	26.48	3.00
4.00	Subtotal other wages & related costs (see inst.)	14,594,669	0	14,594,669	323,283.00	45.15	4.00
5.00	Subtotal wage-related costs (see inst.)	15,051,410	0	15,051,410	0.00	26.72	5.00
6.00	Total (sum of lines 3 thru 5)	92,942,597	-6,968,525	85,974,072	2,450,529.26	35.08	6.00
7.00	Total overhead cost (see instructions)	16,496,285	108,750	16,605,035	647,807.01	25.63	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2015 11:57 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		4,007,179	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)		7,136,617	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		169,071	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		38,822	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)		379,078	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		927,244	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		5,382,923	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		141,259	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		166,540	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		18,348,733	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Prepared: 5/26/2015 11:57 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		4,250,171	0 1.00
2.00	Hospital		4,250,171	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		0	0 8.00
9.00	Hospital-Based NF			0 9.00
10.00	Hospital-Based OLTC			0 10.00
11.00	Hospital-Based HHA			0 11.00
12.00	Separately Certified ASC			0 12.00
13.00	Hospital-Based Hospice			0 13.00
14.00	Hospital-Based Health Clinic RHC			0 14.00
15.00	Hospital-Based Health Clinic FQHC			0 15.00
16.00	Hospital-Based-CMHC			0 16.00
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140224

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

Worksheet S-7

Date/Time Prepared:
5/26/2015 11:57 am

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	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	11	0	11 4.00
5.00		RVX	33	0	33 5.00
6.00		RVL	299	0	299 6.00
7.00		RHX	18	0	18 7.00
8.00		RHL	348	0	348 8.00
9.00		RMX	44	0	44 9.00
10.00		RML	54	0	54 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	26	0	26 12.00
13.00		RUB	14	0	14 13.00
14.00		RUA	103	0	103 14.00
15.00		RVC	132	0	132 15.00
16.00		RVB	242	0	242 16.00
17.00		RVA	802	0	802 17.00
18.00		RHC	194	0	194 18.00
19.00		RHB	515	0	515 19.00
20.00		RHA	826	0	826 20.00
21.00		RMC	73	0	73 21.00
22.00		RMB	45	0	45 22.00
23.00		RMA	122	0	122 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	4	0	4 27.00
28.00		ES1	73	0	73 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	10	0	10 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	1	0	1 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	24	0	24 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	6	0	6 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	13	0	13 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	3	0	3 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	10	0	10 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	33	0	33 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	64	0	64 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	133	0	133 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	185	0	185 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	3	0	3 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140224

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

Worksheet S-7

Date/Time Prepared:
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		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	4	0	4	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	20	0	20	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	7	0	7	78.00
199.00		AAA	12	0	12	199.00
200.00	TOTAL		4,506	0	4,506	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).			16974	16974	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing			0	0.00	202.00
203.00	Recruitment			0	0.00	203.00
204.00	Retention of employees			0	0.00	204.00
205.00	Training			0	0.00	205.00
206.00	OTHER (SPECIFY)			0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)			5,495,583		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/26/2015 11:57 am
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			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)		0.200041	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		11,099,424	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		209,618	5.00
6.00	Medicaid charges		77,936,862	6.00
7.00	Medicaid cost (line 1 times line 6)		15,590,568	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)		4,281,526	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,281,526	19.00
			1.00	
			1.00	
			2.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	Uninsured patients	6,113,379	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	Insured patients	558,775	21.00
22.00	Partial payment by patients approved for charity care	Total (col. 1 + col. 2)	6,672,154	22.00
23.00	Cost of charity care (line 21 minus line 22)		1,334,704	23.00
			1.00	
			2.00	
			0	
			55,222	
			56,556	
			55,222	
			1,279,482	
			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)		7,139,863	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		816,722	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		6,323,141	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,264,887	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,544,369	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,825,895	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES					Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet A Date/Time Prepared: 5/26/2015 11:57 am	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		10,350,549	10,350,549	-12,040,802	-1,690,253	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	12,040,802	12,040,802	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	38,386	185	38,571	17,028,257	17,066,828	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	20,535	20,535	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	0	0	0	5.03
5.04	00570	ADMINITTING	0	0	0	59	59	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	5,902,452	38,847,251	44,749,703	-1,320,873	43,428,830	5.06
6.00	00600	MAINTENANCE & REPAIRS	418,459	587,255	1,005,714	-92,586	913,128	6.00
7.00	00700	OPERATION OF PLANT	677,970	5,313,490	5,991,460	-135,072	5,856,388	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	883,672	883,672	-230	883,442	8.00
9.00	00900	HOUSEKEEPING	1,253,079	1,557,665	2,810,744	-602,862	2,207,882	9.00
10.00	01000	DIETARY	1,512,701	2,844,938	4,357,639	-2,274,057	2,083,582	10.00
11.00	01100	CAFETERIA	0	0	0	1,655,516	1,655,516	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,792,670	403,501	2,196,171	-319,563	1,876,608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-328,569	-328,569	-93,739	-422,308	14.00
15.00	01500	PHARMACY	2,544,122	6,155,422	8,699,544	-6,299,640	2,399,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	753,046	700,051	1,453,097	-217,948	1,235,149	16.00
17.00	01700	SOCIAL SERVICE	1,396,369	391,264	1,787,633	-388,055	1,399,578	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	6,968,525	6,968,525	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	12,514,525	5,412,118	17,926,643	-10,348,326	7,578,317	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,658,027	7,116,041	22,774,068	-5,298,385	17,475,683	30.00
31.00	03100	INTENSIVE CARE UNIT	2,327,836	886,867	3,214,703	-711,038	2,503,665	31.00
40.00	04000	SUBPROVIDER - I PF	2,736,603	723,068	3,459,671	0	3,459,671	40.00
41.00	04100	SUBPROVIDER - I RF	926,286	257,601	1,183,887	-229,997	953,890	41.00
43.00	04300	NURSERY	1,557,941	408,917	1,966,858	70,496	2,037,354	43.00
44.00	04400	SKILLED NURSING FACILITY	1,532,288	549,914	2,082,202	-423,812	1,658,390	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,136,319	14,945,542	20,081,861	-9,935,576	10,146,285	50.00
51.00	05100	RECOVERY ROOM	611,432	144,608	756,040	-139,224	616,816	51.00
53.00	05300	ANESTHESIOLOGY	125,716	618,427	744,143	-173,467	570,676	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,498,674	1,332,120	3,830,794	-570,796	3,259,998	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,011,622	1,643,985	2,655,607	-222,266	2,433,341	55.00
57.00	05700	CT SCAN	315,917	216,644	532,561	-136,372	396,189	57.00
58.00	05800	MRI	283,103	121,545	404,648	-67,066	337,582	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,026,442	2,040,720	3,067,162	-1,908,575	1,158,587	59.00
60.00	06000	LABORATORY	0	7,851,723	7,851,723	-603,835	7,247,888	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	603,835	603,835	63.00
65.00	06500	RESPIRATORY THERAPY	1,014,094	439,518	1,453,612	-331,692	1,121,920	65.00
66.00	06600	PHYSICAL THERAPY	2,945,416	1,132,880	4,078,296	-642,200	3,436,096	66.00
69.00	06900	ELECTROCARDIOLOGY	397,929	1,261,542	1,659,471	-105,136	1,554,335	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,769	25,037	76,806	-17,917	58,889	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,274,150	7,274,150	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,380,695	5,380,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,657,859	6,657,859	73.00
74.00	07400	RENAL DIALYSIS	0	436,715	436,715	-3,574	433,141	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	67,279	16,097	83,376	-15,439	67,937	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	339,154	124,091	463,245	-99,492	363,753	90.00
91.00	09100	EMERGENCY	1,817,844	1,283,338	3,101,182	-607,716	2,493,466	91.00
91.01	09101	PARTIAL HOSPITALIZATION	220,141	58,670	278,811	-46,121	232,690	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,405,611	116,754,402	188,160,013	1,277,280	189,437,293	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	4,257,155	3,188,158	7,445,313	-1,277,280	6,168,033	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	75,662,766	119,942,560	195,605,326	0	195,605,326	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140224

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

Worksheet A
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	-1,690,253	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	775,752	12,816,554	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	355,018	17,421,846	4.00
5.01	00540	NONPATIENT TELEPHONES	0	20,535	5.01
5.02	00550	DATA PROCESSING	2,860,138	2,860,138	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	272,276	272,276	5.03
5.04	00570	ADMINISTRATIVE	0	59	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	2,743,896	2,743,896	5.05
5.06	00591	ADMINISTRATION & GENERAL	-11,481,171	31,947,659	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	913,128	6.00
7.00	00700	OPERATION OF PLANT	0	5,856,388	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	883,442	8.00
9.00	00900	HOUSEKEEPING	0	2,207,882	9.00
10.00	01000	DIETARY	0	2,083,582	10.00
11.00	01100	CAFETERIA	-1,226,395	429,121	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,876,608	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	411,328	-10,980	14.00
15.00	01500	PHARMACY	0	2,399,904	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-962	1,234,187	16.00
17.00	01700	SOCIAL SERVICE	0	1,399,578	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	6,968,525	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-908,980	6,669,337	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-749,609	16,726,074	30.00
31.00	03100	INTENSIVE CARE UNIT	439,699	2,943,364	31.00
40.00	04000	SUBPROVIDER - IPF	0	3,459,671	40.00
41.00	04100	SUBPROVIDER - IRF	-300	953,590	41.00
43.00	04300	NURSERY	0	2,037,354	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,658,390	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-557,482	9,588,803	50.00
51.00	05100	RECOVERY ROOM	0	616,816	51.00
53.00	05300	ANESTHESIOLOGY	-297,061	273,615	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,221	3,255,777	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,103,226	1,330,115	55.00
57.00	05700	CT SCAN	0	396,189	57.00
58.00	05800	MRI	0	337,582	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,158,587	59.00
60.00	06000	LABORATORY	-36,153	7,211,735	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	603,835	63.00
65.00	06500	RESPIRATORY THERAPY	-2,000	1,119,920	65.00
66.00	06600	PHYSICAL THERAPY	-24,846	3,411,250	66.00
69.00	06900	ELECTROCARDIOLOGY	-1,076,307	478,028	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-12,582	46,307	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,274,150	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,380,695	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,657,859	73.00
74.00	07400	RENAL DIALYSIS	0	433,141	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	-4,750	63,187	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-2,653	361,100	90.00
91.00	09100	EMERGENCY	-493,625	1,999,841	91.00
91.01	09101	PARTIAL HOSPITALIZATION	-26,871	205,819	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-10,151,087	179,286,206	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER	-2,969,559	3,198,474	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-13,120,646	182,484,680	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet Non-CMS W
Date/Time Prepared: 5/26/2015 11:57 am				
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	NONPATIENT TELEPHONES	00540	NONPATIENT TELEPHONES	5.01
5.02	DATA PROCESSING	00550	DATA PROCESSING	5.02
5.03	PURCHASING, RECEIVING&STORES	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	ADMINISTRATIVE	00570	ADMINISTRATIVE	5.04
5.05	CASHIERING/ACCTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	ADMINISTRATION & GENERAL	00591		5.06
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
12.00	MAINTENANCE OF PERSONNEL	01200		12.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
20.00	NURSING SCHOOL	02000		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
23.00	PARAMEDICAL PRGM-(SPECIFY)	02300		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00	RADIOLOGY-THERAPEUTIC	05500		55.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	62.30
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	OTHER ANCILLARY SERVICE COST CENTER	03950		76.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LI THOTRI PSY	07699	LI THOTRI PSY	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
91.01	PARTIAL HOSPITALIZATION	09101		91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
194.00	OTHER	07950		194.00
194.01	LAKESHORE GUEST UNIT	07951		194.01

COST CENTERS USED IN COST REPORT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet Non-CMS W Date/Time Prepared: 5/26/2015 11:57 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140224

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

Worksheet A-6
Date/Time Prepared:
5/26/2015 11:57 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,657,859	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,410	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	TOTALS		0	6,661,269	
B - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,380,695	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	5,380,695	
C - CHARGABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,274,150	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
	TOTALS		0	7,274,150	

RECLASSIFICATIONS

Provider CCN: 140224

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

Worksheet A-6
Date/Time Prepared:
5/26/2015 11:57 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
D - NURSEY						
1.00	NURSERY	43.00	354,182	86,601	1.00	
	TOTALS		354,182	86,601		
E - CAFETERIA						
1.00	CAFETERIA	11.00	628,802	1,026,714	1.00	
	TOTALS		628,802	1,026,714		
F - PHYSICIAN DEPR CHAIRMAN						
1.00	ADULTS & PEDIATRICS	30.00	614,969	0	1.00	
	TOTALS		614,969	0		
G - TEACHING PHYSICIAN ADMIN						
1.00	ADMINISTRATION & GENERAL	5.06	108,750	0	1.00	
	TOTALS		108,750	0		
H - EQUIP DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,040,802	1.00	
	TOTALS		0	12,040,802		
I - PHONES						
1.00	NONPATIENT TELEPHONES	5.01	0	20,535	1.00	
	TOTALS		0	20,535		
J - CENTRAL SCHEDULING						
1.00	ADMINISTRATION & GENERAL	5.04	0	59	1.00	
	TOTALS		0	59		
K - BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17,035,905	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
	TOTALS		0	17,035,905		
L - INTERNS AND RESIDENTS SALARY						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	7,583,494	0	1.00	
	TOTALS		7,583,494	0		
M - BLOOD RECLASS						
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	603,835	1.00	
	TOTALS		0	603,835		
N - EHR RECLASS						
1.00	ADMINISTRATION & GENERAL	5.06	0	110,551	1.00	
	TOTALS		0	110,551		
500.00	Grand Total: Increases		9,290,197	50,241,116	500.00	

RECLASSIFICATIONS

Provider CCN: 140224

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

Worksheet A-6
Date/Time Prepared:
5/26/2015 11:57 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - DRUGS							
1.00	ADMINISTRATION & GENERAL	5.06	0	8,695	0	1.00	
2.00	OPERATION OF PLANT	7.00	0	15	0	2.00	
3.00	PHARMACY	15.00	0	5,760,138	0	3.00	
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	114	0	4.00	
6.00	ADULTS & PEDIATRICS	30.00	0	233,292	0	6.00	
7.00	INTENSIVE CARE UNIT	31.00	0	36,088	0	7.00	
8.00	SUBPROVIDER - IRF	41.00	0	723	0	8.00	
9.00	NURSERY	43.00	0	17,100	0	9.00	
10.00	SKILLED NURSING FACILITY	44.00	0	6,270	0	10.00	
11.00	OPERATING ROOM	50.00	0	100,146	0	11.00	
12.00	RECOVERY ROOM	51.00	0	8,087	0	12.00	
13.00	ANESTHESIOLOGY	53.00	0	66,990	0	13.00	
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,911	0	14.00	
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,498	0	15.00	
16.00	CT SCAN	57.00	0	8,019	0	16.00	
17.00	MRI	58.00	0	1,337	0	17.00	
18.00	CARDIAC CATHETERIZATION	59.00	0	14,648	0	18.00	
19.00	RESPIRATORY THERAPY	65.00	0	1,271	0	19.00	
21.00	ELECTROCARDIOLOGY	69.00	0	64	0	21.00	
22.00	RENAL DIALYSIS	74.00	0	540	0	22.00	
23.00	CARDIAC REHABILITATION	76.97	0	3	0	23.00	
24.00	EMERGENCY	91.00	0	70,683	0	24.00	
25.00	OTHER	194.00	0	319,637	0	25.00	
	TOTALS		0	6,661,269			
B - IMPLANTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	625	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	32,353	0	2.00	
3.00	INTENSIVE CARE UNIT	31.00	0	285	0	3.00	
4.00	NURSERY	43.00	0	1,980	0	4.00	
5.00	OPERATING ROOM	50.00	0	3,723,687	0	5.00	
6.00	CARDIAC CATHETERIZATION	59.00	0	1,621,655	0	6.00	
7.00	EMERGENCY	91.00	0	110	0	7.00	
	TOTALS		0	5,380,695			
C - CHARGABLE SUPPLIES							
1.00	ADMINISTRATION & GENERAL	5.06	0	24,829	0	1.00	
2.00	MAINTENANCE & REPAIRS	6.00	0	18	0	2.00	
3.00	OPERATION OF PLANT	7.00	0	26	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	230	0	4.00	
5.00	HOUSEKEEPING	9.00	0	30,313	0	5.00	
6.00	DIETARY	10.00	0	44	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	0	13	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	96,524	0	8.00	
9.00	PHARMACY	15.00	0	42,322	0	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	144	0	10.00	
11.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	600	0	11.00	
12.00	ADULTS & PEDIATRICS	30.00	0	1,030,431	0	12.00	
13.00	INTENSIVE CARE UNIT	31.00	0	205,076	0	13.00	
14.00	SUBPROVIDER - IRF	41.00	0	17,414	0	14.00	
15.00	NURSERY	43.00	0	57,652	0	15.00	
16.00	SKILLED NURSING FACILITY	44.00	0	61,643	0	16.00	
17.00	OPERATING ROOM	50.00	0	4,966,189	0	17.00	
18.00	RECOVERY ROOM	51.00	0	15,090	0	18.00	
19.00	ANESTHESIOLOGY	53.00	0	68,741	0	19.00	
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	62,981	0	20.00	
21.00	RADIOLOGY-THERAPEUTIC	55.00	0	10,076	0	21.00	
22.00	CT SCAN	57.00	0	61,343	0	22.00	
23.00	MRI	58.00	0	8,731	0	23.00	
24.00	CARDIAC CATHETERIZATION	59.00	0	77,361	0	24.00	
26.00	RESPIRATORY THERAPY	65.00	0	97,063	0	26.00	
27.00	PHYSICAL THERAPY	66.00	0	49,226	0	27.00	
28.00	ELECTROCARDIOLOGY	69.00	0	10,144	0	28.00	
29.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,647	0	29.00	
30.00	RENAL DIALYSIS	74.00	0	3,034	0	30.00	
31.00	CARDIAC REHABILITATION	76.97	0	172	0	31.00	
32.00	CLINIC	90.00	0	22,798	0	32.00	
33.00	EMERGENCY	91.00	0	136,779	0	33.00	
34.00	OTHER	194.00	0	113,496	0	34.00	
	TOTALS		0	7,274,150			
D - NURSEY							
1.00	ADULTS & PEDIATRICS	30.00	354,182	86,601	0	1.00	
	TOTALS		354,182	86,601			

RECLASSIFICATIONS

Provider CCN: 140224

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

Worksheet A-6
Date/Time Prepared:
5/26/2015 11:57 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
E - CAFETERIA						
1.00	DIETARY	10.00	628,802	1,026,714	0	1.00
	TOTALS		628,802	1,026,714		
F - PHYSICIAN DEPR CHAIRMAN						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	614,969	0	0	1.00
	TOTALS		614,969	0		
G - TEACHING PHYSICIAN ADMIN						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	108,750	0	0	1.00
	TOTALS		108,750	0		
H - EQUIP DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12,040,802	9	1.00
	TOTALS		0	12,040,802		
I - PHONES						
1.00	ADMINISTRATION & GENERAL	5.06	0	20,535	0	1.00
	TOTALS		0	20,535		
J - CENTRAL SCHEDULING						
1.00	ADMINISTRATION & GENERAL	5.06	0	59	0	1.00
	TOTALS		0	59		
K - BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,648	0	1.00
2.00	ADMINISTRATION & GENERAL	5.06	0	1,486,056	0	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	92,568	0	3.00
4.00	OPERATION OF PLANT	7.00	0	135,031	0	4.00
5.00	HOUSEKEEPING	9.00	0	572,549	0	5.00
6.00	DIETARY	10.00	0	618,497	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	319,550	0	7.00
8.00	PHARMACY	15.00	0	497,180	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	217,690	0	9.00
10.00	SOCIAL SERVICE	17.00	0	277,504	0	10.00
11.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	2,655,482	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	0	4,176,495	0	12.00
13.00	INTENSIVE CARE UNIT	31.00	0	469,589	0	13.00
14.00	SUBPROVIDER - IRF	41.00	0	211,860	0	14.00
15.00	NURSERY	43.00	0	293,555	0	15.00
16.00	SKILLED NURSING FACILITY	44.00	0	355,899	0	16.00
17.00	OPERATING ROOM	50.00	0	1,145,554	0	17.00
18.00	RECOVERY ROOM	51.00	0	116,047	0	18.00
19.00	ANESTHESIOLOGY	53.00	0	37,736	0	19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	503,904	0	20.00
21.00	RADIOLOGY-THERAPEUTIC	55.00	0	208,692	0	21.00
22.00	CT SCAN	57.00	0	67,010	0	22.00
23.00	MRI	58.00	0	56,998	0	23.00
24.00	CARDIAC CATHETERIZATION	59.00	0	194,911	0	24.00
25.00	RESPIRATORY THERAPY	65.00	0	233,358	0	25.00
26.00	PHYSICAL THERAPY	66.00	0	592,974	0	26.00
27.00	ELECTROCARDIOLOGY	69.00	0	94,928	0	27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	14,270	0	28.00
29.00	CARDIAC REHABILITATION	76.97	0	15,264	0	29.00
30.00	CLINIC	90.00	0	76,694	0	30.00
31.00	EMERGENCY	91.00	0	400,144	0	31.00
32.00	PARTIAL HOSPITALIZATION	91.01	0	46,121	0	32.00
33.00	OTHER	194.00	0	844,147	0	33.00
	TOTALS		0	17,035,905		
L - INTERNS AND RESIDENTS SALARY						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	7,583,494	0	0	1.00
	TOTALS		7,583,494	0		
M - BLOOD RECLASS						
1.00	LABORATORY	60.00	0	603,835	0	1.00
	TOTALS		0	603,835		
N - EHR RECLASS						
1.00	SOCIAL SERVICE	17.00	0	110,551	0	1.00
	TOTALS		0	110,551		
500.00	Grand Total: Decreases		9,290,197	50,241,116		500.00

RECLASSIFICATIONS

Provider CCN: 140224

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/26/2015 11:57 am

Increases					Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - DRUGS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,657,859	ADMINISTRATION & GENERAL	5.06	0	8,695	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,410	OPERATION OF PLANT	7.00	0	15	2.00
3.00		0.00	0	0	PHARMACY	15.00	0	5,760,138	3.00
4.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	114	4.00
6.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	233,292	6.00
7.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	36,088	7.00
8.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	723	8.00
9.00		0.00	0	0	NURSERY	43.00	0	17,100	9.00
10.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	6,270	10.00
11.00		0.00	0	0	OPERATING ROOM	50.00	0	100,146	11.00
12.00		0.00	0	0	RECOVERY ROOM	51.00	0	8,087	12.00
13.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	66,990	13.00
14.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	3,911	14.00
15.00		0.00	0	0	RADIOLOGY-THERAPEUTIC	55.00	0	3,498	15.00
16.00		0.00	0	0	CT SCAN	57.00	0	8,019	16.00
17.00		0.00	0	0	MRI	58.00	0	1,337	17.00
18.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	14,648	18.00
19.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	1,271	19.00
21.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	64	21.00
22.00		0.00	0	0	RENAL DIALYSIS	74.00	0	540	22.00
23.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	3	23.00
24.00		0.00	0	0	EMERGENCY	91.00	0	70,683	24.00
25.00		0.00	0	0	OTHER	194.00	0	319,637	25.00
	TOTALS		0	6,661,269	TOTALS		0	6,661,269	
B - IMPLANTS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,380,695	CENTRAL SERVICES & SUPPLY	14.00	0	625	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	32,353	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	285	3.00
4.00		0.00	0	0	NURSERY	43.00	0	1,980	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	3,723,687	5.00
6.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	1,621,655	6.00
7.00		0.00	0	0	EMERGENCY	91.00	0	110	7.00
	TOTALS		0	5,380,695	TOTALS		0	5,380,695	
C - CHARGABLE SUPPLIES									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,274,150	ADMINISTRATION & GENERAL	5.06	0	24,829	1.00
2.00		0.00	0	0	MAINTENANCE & REPAIRS	6.00	0	18	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	0	26	3.00
4.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	0	230	4.00
5.00		0.00	0	0	HOUSEKEEPING	9.00	0	30,313	5.00
6.00		0.00	0	0	DIETARY	10.00	0	44	6.00
7.00		0.00	0	0	NURSING	13.00	0	13	7.00
8.00		0.00	0	0	ADMINISTRATION	14.00	0	96,524	8.00
9.00		0.00	0	0	PHARMACY	15.00	0	42,322	9.00
10.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	144	10.00
11.00		0.00	0	0	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	600	11.00
12.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	1,030,431	12.00
13.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	205,076	13.00
14.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	17,414	14.00
15.00		0.00	0	0	NURSERY	43.00	0	57,652	15.00
16.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	61,643	16.00
17.00		0.00	0	0	OPERATING ROOM	50.00	0	4,966,189	17.00
18.00		0.00	0	0	RECOVERY ROOM	51.00	0	15,090	18.00
19.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	68,741	19.00
20.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	62,981	20.00
21.00		0.00	0	0	RADIOLOGY-THERAPEUTIC	55.00	0	10,076	21.00
22.00		0.00	0	0	CT SCAN	57.00	0	61,343	22.00
23.00		0.00	0	0	MRI	58.00	0	8,731	23.00
24.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	77,361	24.00

RECLASSIFICATIONS

Provider CCN: 140224

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/26/2015 11:57 am

Increases					Decreases						
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00			
26.00	0.00	0	0	0	RESPIRATORY THERAPY	65.00	0	97,063	26.00		
27.00	0.00	0	0	0	PHYSICAL THERAPY	66.00	0	49,226	27.00		
28.00	0.00	0	0	0	ELECTROCARDIOLOGY	69.00	0	10,144	28.00		
29.00	0.00	0	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	3,647	29.00		
30.00	0.00	0	0	0	RENAL DIALYSIS	74.00	0	3,034	30.00		
31.00	0.00	0	0	0	CARDIAC REHABILITATION	76.97	0	172	31.00		
32.00	0.00	0	0	0	CLINIC	90.00	0	22,798	32.00		
33.00	0.00	0	0	0	EMERGENCY	91.00	0	136,779	33.00		
34.00	0.00	0	0	0	OTHER	194.00	0	113,496	34.00		
TOTALS				0	7,274,150	TOTALS				0	7,274,150
D - NURSEY											
1.00	NURSERY	43.00	354,182	86,601	ADULTS & PEDIATRICS	30.00	354,182	86,601		1.00	
TOTALS				354,182	86,601	TOTALS				354,182	86,601
E - CAFETERIA											
1.00	CAFETERIA	11.00	628,802	1,026,714	DIETARY	10.00	628,802	1,026,714		1.00	
TOTALS				628,802	1,026,714	TOTALS				628,802	1,026,714
F - PHYSICIAN DEPARTMENT											
1.00	ADULTS & PEDIATRICS	30.00	614,969	0	I&R SERVICES-SALARY & FRINGES APPRV	21.00	614,969	0		1.00	
TOTALS				614,969	0	TOTALS				614,969	0
G - TEACHING PHYSICIAN ADMIN											
1.00	ADMINISTRATION & GENERAL	5.06	108,750	0	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	108,750	0		1.00	
TOTALS				108,750	0	TOTALS				108,750	0
H - EQUIP DEPRECIATION											
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,040,802	CAP REL COSTS-BLDG & FIXT	1.00	0	12,040,802		1.00	
TOTALS				0	12,040,802	TOTALS				0	12,040,802
I - PHONES											
1.00	NONPATIENT TELEPHONES	5.01	0	20,535	ADMINISTRATION & GENERAL	5.06	0	20,535		1.00	
TOTALS				0	20,535	TOTALS				0	20,535
J - CENTRAL SCHEDULING											
1.00	ADMINISTRATIVE	5.04	0	59	ADMINISTRATION & GENERAL	5.06	0	59		1.00	
TOTALS				0	59	TOTALS				0	59
K - BENEFITS											
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17,035,905	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,648		1.00	
2.00		0.00	0	0	ADMINISTRATION & GENERAL	5.06	0	1,486,056		2.00	
3.00		0.00	0	0	MAINTENANCE & REPAIRS	6.00	0	92,568		3.00	
4.00		0.00	0	0	OPERATION OF PLANT	7.00	0	135,031		4.00	
5.00		0.00	0	0	HOUSEKEEPING	9.00	0	572,549		5.00	
6.00		0.00	0	0	DIETARY	10.00	0	618,497		6.00	
7.00		0.00	0	0	NURSING	13.00	0	319,550		7.00	
8.00		0.00	0	0	ADMINISTRATION		0				
9.00		0.00	0	0	PHARMACY	15.00	0	497,180		8.00	
10.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	217,690		9.00	
11.00		0.00	0	0	SOCIAL SERVICE	17.00	0	277,504		10.00	
12.00		0.00	0	0	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	2,655,482		11.00	
13.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	4,176,495		12.00	
14.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	469,589		13.00	
15.00		0.00	0	0	SUBPROVIDER - IIRF	41.00	0	211,860		14.00	
16.00		0.00	0	0	NURSERY	43.00	0	293,555		15.00	
17.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	355,899		16.00	
18.00		0.00	0	0	OPERATING ROOM	50.00	0	1,145,554		17.00	
19.00		0.00	0	0	RECOVERY ROOM	51.00	0	116,047		18.00	
20.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	37,736		19.00	
21.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	503,904		20.00	
22.00		0.00	0	0	RADIOLOGY-THERAPEUTIC	55.00	0	208,692		21.00	
23.00		0.00	0	0	CT SCAN	57.00	0	67,010		22.00	
24.00		0.00	0	0	MRI	58.00	0	56,998		23.00	
25.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	194,911		24.00	
26.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	233,358		25.00	
27.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	592,974		26.00	
28.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	94,928		27.00	
		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	14,270		28.00	

RECLASSIFICATIONS

Provider CCN: 140224

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/26/2015 11:57 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
29.00		0.00	0	0	0	76.97	0	15,264	29.00
					0				
30.00		0.00	0	0	0	90.00	0	76,694	30.00
31.00		0.00	0	0	0	91.00	0	400,144	31.00
32.00		0.00	0	0	0	91.01	0	46,121	32.00
					0				
33.00		0.00	0	0	0	194.00	0	844,147	33.00
	TOTALS		0	17,035,905	TOTALS		0	17,035,905	
L - INTERNS AND RESIDENTS SALARY									
1.00	I & R SERVICES-SALARY & FRINGES APPRV	21.00	7,583,494	0	I & R SERVICES-OTHER PRGM COSTS APPRV	22.00	7,583,494	0	1.00
	TOTALS		7,583,494	0	TOTALS		7,583,494	0	
M - BLOOD RECLASS									
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	603,835	LABORATORY	60.00	0	603,835	1.00
	TOTALS		0	603,835	TOTALS		0	603,835	
N - EHR RECLASS									
1.00	ADMINISTRATION & GENERAL	5.06	0	110,551	SOCIAL SERVICE	17.00	0	110,551	1.00
	TOTALS		0	110,551	TOTALS		0	110,551	
500.00	Grand Total: Increases		9,290,197	50,241,116	Grand Total: Decreases		9,290,197	50,241,116	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140224

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

Worksheet A-7
Part I
Date/Time Prepared:
5/26/2015 11:57 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,327,665	0	0	0	1.00
2.00	Land Improvements	11,980,239	0	0	0	2.00
3.00	Buildings and Fixtures	65,594,666	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	54,218,342	5,202,843	0	5,202,843	1,024,253
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139,120,912	5,202,843	0	5,202,843	1,024,253
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	139,120,912	5,202,843	0	5,202,843	1,024,253
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,327,665	0			1.00
2.00	Land Improvements	11,980,239	0			2.00
3.00	Buildings and Fixtures	65,594,666	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	58,396,932	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	143,299,502	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	143,299,502	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140224

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

Worksheet A-7
Part II
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	10,350,549	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,350,549	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	10,350,549				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	10,350,549				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140224

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

Worksheet A-7
Part III
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	84,902,570	0	84,902,570	0.592483	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	58,396,932	0	58,396,932	0.407517	0	2.00
3.00	Total (sum of lines 1-2)	143,299,502	0	143,299,502	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	-1,690,253	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	12,816,554	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	11,126,301	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	-1,690,253	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	12,816,554	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	11,126,301	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140224

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

Worksheet A-8

Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-4,799,674				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	-1,711,336				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,226,395	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	-962	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			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	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	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 MISC INCOME	B	-270	PHYSICAL THERAPY		66.00	0	33.00
34.00 MISC REVENUE	B	-4,221	RADIOLOGY-DIAGNOSTIC		54.00	0	34.00

Provider CCN: 140224
 Period: From 01/01/2014 To 12/31/2014
 Worksheet A-8
 Date/Time Prepared: 5/26/2015 11:57 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
38.00 MISC INCOME	A	-2,653	CLINIC	90.00	0 38.00
39.00 MOONLIGHTERS	A	-316,762	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0 39.00
40.00 MISC INCOME	A	-3,000	EMERGENCY	91.00	0 40.00
42.00 PHYS FEES	A	-2,969,559	OTHER	194.00	0 42.00
43.02 MISC INCOME	B	-364	PHYSICAL THERAPY	66.00	0 43.02
43.03 MISC INCOME	B	-985,769	ADMINISTRATION & GENERAL	5.06	0 43.03
43.04 MISC INCOME	B	-46,117	RADIOLOGY-THERAPEUTIC	55.00	0 43.04
43.05		0		0.00	0 43.05
43.10 AHA, IHA AND MCHC DUES	A	-42,678	ADMINISTRATION & GENERAL	5.06	0 43.10
44.00 MISC INCOME	B	-592,218	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0 44.00
45.00 MISC INCOME	B	-12,582	ELECTROENCEPHALOGRAPHY	70.00	0 45.00
46.00 MISC INCOME	B	-2,000	RESPIRATORY THERAPY	65.00	0 46.00
47.00 MISC INCOME	B	-4,750	CARDIAC REHABILITATION	76.97	0 47.00
48.00 BENEFITS ON PART B DOCS	A	-399,336	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 48.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,120,646			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 140224

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

Worksheet A-8-1

Date/Time Prepared: 5/26/2015 11:57 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	754,354	0
2.00	5.05	CASHIERING/ACCTS RECEIVABLE	PFS	2,743,896	0
3.00	5.03	PURCHASING, RECEIVING&STORES	PURCH, RECEIVING	272,276	0
3.01	5.02	DATA PROCESSING	IS	2,860,138	0
3.02	5.06	ADMINISTRATION & GENERAL	A & G	10,202,461	20,166,587
3.03	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	411,328	0
3.04	31.00	INTENSIVE CARE UNIT	EICU	439,699	0
3.05	2.00	CAP REL COSTS-MVBLE EQUIP	CRC	775,752	0
3.06	0.00			0	0
3.07	60.00	LABORATORY	ALVERNO LAB	7,179,873	7,184,526
4.00	0.00			0	0
4.01	0.00			0	0
4.02	0.00			0	0
4.03	0.00			0	0
4.04	0.00			0	0
4.05	0.00			0	0
4.06	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			25,639,777	27,351,113

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

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

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

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

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

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

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

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

Provider CCN: 140224

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

Worksheet A-8-1

Date/Time Prepared:
5/26/2015 11:57 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	754,354	0		1.00
2.00	2,743,896	0		2.00
3.00	272,276	0		3.00
3.01	2,860,138	0		3.01
3.02	-9,964,126	0		3.02
3.03	411,328	0		3.03
3.04	439,699	0		3.04
3.05	775,752	9		3.05
3.06	0	0		3.06
3.07	-4,653	0		3.07
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
5.00	-1,711,336	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	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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	SOLE CORPORATE MEMBER		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140224

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

Worksheet A-8-2

Date/Time Prepared:
5/26/2015 11:57 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,165,859	516,000	649,859	177,200	4,886	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	300	300	0	0	0	3.00
4.00	50.00	OPERATING ROOM	557,482	557,482	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	297,061	297,061	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	1,057,109	1,057,109	0	0	0	6.00
7.00	60.00	LABORATORY	31,500	31,500	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	24,212	24,212	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	1,076,307	1,076,307	0	0	0	9.00
10.00	91.00	EMERGENCY	490,625	490,625	0	0	0	10.00
11.00	91.01	PARTIAL HOSPITALIZATION	26,871	26,871	0	0	0	11.00
12.00	5.06	ADMINISTRATION & GENERAL	573,279	424,324	148,955	177,200	994	12.00
200.00			5,300,605	4,501,791	798,814		5,880	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	416,250	20,813	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	0	0	11.00
12.00	5.06	ADMINISTRATION & GENERAL	84,681	4,234	0	0	0	12.00
200.00			500,931	25,047	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	416,250	233,609	749,609	1.00
2.00	0.00		0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	300	3.00
4.00	50.00	OPERATING ROOM	0	0	0	557,482	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	297,061	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	1,057,109	6.00
7.00	60.00	LABORATORY	0	0	0	31,500	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	24,212	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,076,307	9.00
10.00	91.00	EMERGENCY	0	0	0	490,625	10.00
11.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	26,871	11.00
12.00	5.06	ADMINISTRATION & GENERAL	0	84,681	64,274	488,598	12.00
200.00			0	500,931	297,883	4,799,674	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	-1,690,253	-1,690,253			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	12,816,554		12,816,554		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	17,421,846	0	0	17,421,846	4.00
5.01 00540	NONPATIENT TELEPHONES	20,535	0	0	0	20,535 5.01
5.02 00550	DATA PROCESSING	2,860,138	0	0	0	0 5.02
5.03 00560	PURCHASING, RECEIVING&STORES	272,276	0	0	0	332 5.03
5.04 00570	ADMINISTRATIVE	59	0	0	0	590 5.04
5.05 00580	CASHIERING/ACCTS RECEIVABLE	2,743,896	0	3,078	0	923 5.05
5.06 00591	ADMINISTRATION & GENERAL	31,947,659	0	4,325,010	1,384,819	2,509 5.06
6.00 00600	MAINTENANCE & REPAIRS	913,128	0	0	96,402	0 6.00
7.00 00700	OPERATION OF PLANT	5,856,388	0	455,755	156,186	849 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	883,442	0	27,948	0	74 8.00
9.00 00900	HOUSEKEEPING	2,207,882	0	493,626	288,676	111 9.00
10.00 01000	DIETARY	2,083,582	0	470,874	203,626	148 10.00
11.00 01100	CAFETERIA	429,121	0	0	144,859	221 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	1,876,608	0	48,459	412,983	886 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	-10,980	0	0	0	92 14.00
15.00 01500	PHARMACY	2,399,904	0	91,033	586,097	369 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,234,187	0	188,049	173,481	701 16.00
17.00 01700	SOCIAL SERVICE	1,399,578	0	0	321,686	277 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	6,968,525	0	0	1,605,360	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	6,669,337	0	73,649	1,110,923	978 22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	16,726,074	0	2,487,658	3,667,295	3,136 30.00
31.00 03100	INTENSIVE CARE UNIT	2,943,364	0	352,017	536,271	720 31.00
40.00 04000	SUBPROVIDER - I PF	3,459,671	0	359,724	630,439	0 40.00
41.00 04100	SUBPROVIDER - I RF	953,590	0	149,711	213,391	424 41.00
43.00 04300	NURSERY	2,037,354	0	107,186	440,502	148 43.00
44.00 04400	SKILLED NURSING FACILITY	1,658,390	0	373,661	352,998	221 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	9,588,803	0	979,324	1,183,269	1,513 50.00
51.00 05100	RECOVERY ROOM	616,816	0	50,946	140,857	0 51.00
53.00 05300	ANESTHESIOLOGY	273,615	0	21,619	28,962	37 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,255,777	0	519,161	575,627	1,494 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	1,330,115	0	143,185	233,050	0 55.00
57.00 05700	CT SCAN	396,189	0	38,240	72,779	0 57.00
58.00 05800	MRI	337,582	0	21,053	65,219	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	1,158,587	0	242,393	236,465	0 59.00
60.00 06000	LABORATORY	7,211,735	0	268,666	0	1,070 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	603,835	0	0	0	0 63.00
65.00 06500	RESPIRATORY THERAPY	1,119,920	0	79,140	233,620	258 65.00
66.00 06600	PHYSICAL THERAPY	3,411,250	0	161,382	678,544	517 66.00
69.00 06900	ELECTROCARDIOLOGY	478,028	0	0	91,672	295 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	46,307	0	936	11,926	240 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,274,150	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,380,695	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,657,859	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	433,141	0	0	0	111 74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	63,187	0	0	15,499	55 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	361,100	0	13,395	78,132	775 90.00
91.00 09100	EMERGENCY	1,999,841	0	0	418,782	461 91.00
91.01 09101	PARTIAL HOSPITALIZATION	205,819	0	0	50,715	0 91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	179,286,206	0	12,546,878	16,441,112	20,535 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER	3,198,474	0	269,676	980,734	0 194.00
194.01 07951	LAKESHORE GUEST UNIT	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

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

Worksheet B
Part I
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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	
201.00 Negative Cost Centers		-1,690,253	0	0		0 201.00
202.00 TOTAL (sum lines 118-201)	182,484,680	-1,690,253	12,816,554	17,421,846	20,535	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared: 5/26/2015 11:57 am			
Cost Center Description			DATA PROCESSING 5.02	PURCHASING, RECEIVING & STORES 5.03	ADMINISTRATIVE 5.04	CASHIERING/ACCOUNTS RECEIVABLE 5.05	Subtotal 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	2,860,138					5.02
5.03	00560	PURCHASING, RECEIVING & STORES	0	272,608				5.03
5.04	00570	ADMINISTRATIVE	0	0	649			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	2,747,897		5.05
5.06	00591	ADMINISTRATION & GENERAL	2,860,138	8,239	0	0	40,528,374	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	95	0	0	1,009,625	6.00
7.00	00700	OPERATION OF PLANT	0	80	0	0	6,469,258	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	911,464	8.00
9.00	00900	HOUSEKEEPING	0	3,296	0	0	2,993,591	9.00
10.00	01000	DIETARY	0	4,808	0	0	2,763,038	10.00
11.00	01100	CAFETERIA	0	0	0	0	574,201	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	470	0	0	2,339,406	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	653	0	0	-10,235	14.00
15.00	01500	PHARMACY	0	1,071	0	0	3,078,474	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,216	0	0	1,597,634	16.00
17.00	01700	SOCIAL SERVICE	0	42	0	0	1,721,583	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	8,573,885	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	6,987	0	0	7,861,874	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,444	280	400,400	23,291,287	30.00
31.00	03100	INTENSIVE CARE UNIT	0	216	13	43,979	3,876,580	31.00
40.00	04000	SUBPROVIDER - I/PF	0	891	17	60,638	4,511,380	40.00
41.00	04100	SUBPROVIDER - I/RF	0	297	4	15,613	1,333,030	41.00
43.00	04300	NURSERY	0	528	11	38,186	2,623,915	43.00
44.00	04400	SKILLED NURSING FACILITY	0	722	5	19,300	2,405,297	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	13,791	30	347,482	12,114,212	50.00
51.00	05100	RECOVERY ROOM	0	51	5	49,918	858,593	51.00
53.00	05300	ANESTHESIOLOGY	0	39	8	85,513	409,793	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	902	14	143,990	4,496,965	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	706	0	37,027	1,744,083	55.00
57.00	05700	CT SCAN	0	251	9	90,119	597,587	57.00
58.00	05800	MRI	0	26	5	56,114	479,999	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,729	11	67,663	1,706,848	59.00
60.00	06000	LABORATORY	0	0	52	286,885	7,768,408	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	4	15,411	619,250	63.00
65.00	06500	RESPIRATORY THERAPY	0	91	11	40,331	1,473,371	65.00
66.00	06600	PHYSICAL THERAPY	0	607	10	61,922	4,314,232	66.00
69.00	06900	ELECTROCARDIOLOGY	0	129	9	70,826	640,959	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	83	0	6,007	65,499	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	215,887	28	165,059	7,655,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12	76,170	5,456,877	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	96	420,861	7,078,816	73.00
74.00	07400	RENAL DIALYSIS	0	0	2	7,469	440,723	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	16	0	936	79,693	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	32	0	10,664	464,098	90.00
91.00	09100	EMERGENCY	0	1,042	13	125,642	2,545,781	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	18	0	3,772	260,324	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,860,138	271,455	649	2,747,897	179,724,896	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	1,153	0	0	4,450,037	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	-1,690,253	201.00
202.00		TOTAL (sum lines 118-201)	2,860,138	272,608	649	2,747,897	182,484,680	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

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

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Cost Center Description		ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
6.00	00600	40,528,374	284,834	1,294,459			6.00
7.00	00700	1,825,101	69,501	8,363,860			7.00
8.00	00800	257,141	4,262	29,100	1,201,967		8.00
9.00	00900	844,549	75,276	513,976	838	4,428,230	9.00
10.00	01000	779,506	71,807	490,286	0	277,606	10.00
11.00	01100	161,993	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	659,991	7,390	50,457	0	28,569	13.00
14.00	01400	0	0	0	518	0	14.00
15.00	01500	868,496	13,882	94,786	0	53,669	15.00
16.00	01600	450,723	28,677	195,802	0	110,865	16.00
17.00	01700	485,691	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	2,418,856	0	0	0	0	21.00
22.00	02200	2,217,984	11,231	76,685	0	43,420	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,570,979	379,357	2,590,211	565,015	1,466,612	30.00
31.00	03100	1,093,657	53,681	366,529	53,925	207,533	31.00
40.00	04000	1,272,746	54,857	374,554	41,305	212,077	40.00
41.00	04100	376,073	22,830	155,882	55,596	88,263	41.00
43.00	04300	740,256	16,345	111,605	0	63,192	43.00
44.00	04400	678,580	56,982	389,065	89,781	220,294	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,417,649	149,343	1,019,697	156,853	577,365	50.00
51.00	05100	242,225	7,769	53,046	26,314	30,035	51.00
53.00	05300	115,610	3,297	22,511	0	12,746	53.00
54.00	05400	1,268,679	79,170	540,563	76,922	306,074	54.00
55.00	05500	492,039	21,835	149,088	14,842	84,416	55.00
57.00	05700	168,591	5,831	39,817	4,838	22,545	57.00
58.00	05800	135,417	3,211	21,921	0	12,412	58.00
59.00	05900	481,534	36,964	252,386	27,648	142,904	59.00
60.00	06000	2,191,615	40,971	279,742	15,600	158,394	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	174,702	0	0	0	0	63.00
65.00	06500	415,666	12,069	82,402	2	46,657	65.00
66.00	06600	1,217,127	24,610	168,035	4,383	95,144	66.00
69.00	06900	180,827	0	0	9,208	0	69.00
70.00	07000	18,479	143	974	470	552	70.00
71.00	07100	2,159,656	0	0	0	0	71.00
72.00	07200	1,539,489	0	0	0	0	72.00
73.00	07300	1,997,068	0	0	0	0	73.00
74.00	07400	124,336	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	22,483	0	0	1,307	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	130,931	2,043	13,947	18,765	7,897	90.00
91.00	09100	718,213	0	0	36,122	0	91.00
91.01	09101	73,442	0	0	0	0	91.01
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		39,272,934	1,253,334	8,083,067	1,200,252	4,269,241	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	1,255,440	41,125	280,793	1,715	158,989	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		40,528,374	1,294,459	8,363,860	1,201,967	4,428,230	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	4,382,243					10.00
11.00	01100	CAFETERIA	0	736,194				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	13,036	0	3,098,849		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	-9,717	14.00
15.00	01500	PHARMACY	0	21,358	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,201	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	11,880	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	123,437	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,998,501	186,865	0	1,463,310	0	30.00
31.00	03100	INTENSIVE CARE UNIT	115,976	24,473	0	266,932	0	31.00
40.00	04000	SUBPROVIDER - I PF	644,426	32,787	0	187,101	0	40.00
41.00	04100	SUBPROVIDER - I RF	180,872	13,258	0	102,595	0	41.00
43.00	04300	NURSERY	0	16,124	0	168,296	0	43.00
44.00	04400	SKILLED NURSING FACILITY	442,468	20,333	0	143,805	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	73,211	0	285,543	0	50.00
51.00	05100	RECOVERY ROOM	0	8,806	0	82,645	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,015	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,053	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,031	0	14,019	0	55.00
57.00	05700	CT SCAN	0	2,956	0	131	0	57.00
58.00	05800	MRI	0	3,780	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	15,535	0	103,771	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	14,255	0	139	0	65.00
66.00	06600	PHYSICAL THERAPY	0	25,996	0	784	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,411	0	2,023	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	713	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	755	0	7,962	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,801	0	9,050	0	90.00
91.00	09100	EMERGENCY	0	21,344	0	164,578	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	2,250	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,382,243	696,664	0	3,002,684	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	39,530	0	96,165	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	-9,717	201.00
202.00		TOTAL (sum lines 118-201)	4,382,243	736,194	0	3,098,849	-9,717	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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&STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	4,130,665					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,394,902				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,219,154			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	348,982	1,342,126	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	38,331	112,252	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	52,851	310,770	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	13,608	90,984	0	0	41.00
43.00	04300	NURSERY	0	33,282	170,807	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	16,822	192,215	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	302,860	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	43,508	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	74,532	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	125,499	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	32,272	0	0	0	55.00
57.00	05700	CT SCAN	0	78,546	0	0	0	57.00
58.00	05800	MRI	0	48,908	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	58,974	0	0	0	59.00
60.00	06000	LABORATORY	0	250,044	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	13,432	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	35,152	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	53,970	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	61,731	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,236	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	143,862	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	66,389	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,130,665	366,697	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	6,510	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	815	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	9,294	0	0	0	90.00
91.00	09100	EMERGENCY	0	109,507	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	3,288	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,130,665	2,394,902	2,219,154	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,130,665	2,394,902	2,219,154	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
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&STORES					5.03
5.04 00570	ADMINITTING					5.04
5.05 00580	CASHIERING/ACCTS RECEIVABLE					5.05
5.06 00591	ADMINISTRATION & GENERAL					5.06
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	11,116,178				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	10,211,194			22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,665,596	7,041,527	0	55,910,368	-14,707,123
31.00 03100	INTENSIVE CARE UNIT	1,836,524	1,687,010	0	9,733,403	-3,523,534
40.00 04000	SUBPROVIDER - I PF	0	0	0	7,694,854	0
41.00 04100	SUBPROVIDER - I RF	0	0	0	2,432,991	0
43.00 04300	NURSERY	0	0	0	3,943,822	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	4,655,642	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	444,931	408,709	0	18,950,373	-853,640
51.00 05100	RECOVERY ROOM	0	0	0	1,352,941	0
53.00 05300	ANESTHESIOLOGY	0	0	0	640,504	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	241,399	221,746	0	7,387,070	-463,145
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	2,562,625	0
57.00 05700	CT SCAN	0	0	0	920,842	0
58.00 05800	MRI	0	0	0	705,648	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	2,826,564	0
60.00 06000	LABORATORY	97,033	89,133	0	10,890,940	-186,166
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	807,384	0
65.00 06500	RESPIRATORY THERAPY	192,882	177,180	0	2,449,775	-370,062
66.00 06600	PHYSICAL THERAPY	192,882	177,180	0	6,274,343	-370,062
69.00 06900	ELECTROCARDIOLOGY	0	0	0	901,159	0
70.00 07000	ELECTROENCEPHALOGRAPHY	444,931	408,709	0	945,706	-853,640
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,958,642	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,062,755	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,573,246	0
74.00 07400	RENAL DIALYSIS	0	0	0	571,569	0
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	0	0	113,015	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	659,826	0
91.00 09100	EMERGENCY	0	0	0	3,595,545	0
91.01 09101	PARTIAL HOSPITALIZATION	0	0	0	339,304	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,116,178	10,211,194	0	177,860,856	-21,327,372
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER	0	0	0	6,323,794	0
194.01 07951	LAKESHORE GUEST UNIT	0	0	0	0	0
200.00	Cross Foot Adjustments	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
		21.00	22.00				
201.00	Negative Cost Centers	0	0	0	-1,699,970	0	201.00
202.00	TOTAL (sum lines 118-201)	11,116,178	10,211,194	0	182,484,680	-21,327,372	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540 NONPATIENT TELEPHONES		5.01
5.02	00550 DATA PROCESSING		5.02
5.03	00560 PURCHASING, RECEIVING&STORES		5.03
5.04	00570 ADMIN TTING		5.04
5.05	00580 CASHIERING/ACCTS RECEIVABLE		5.05
5.06	00591 ADMINISTRATION & GENERAL		5.06
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	41,203,245	30.00
31.00	03100 INTENSIVE CARE UNIT	6,209,869	31.00
40.00	04000 SUBPROVIDER - IPF	7,694,854	40.00
41.00	04100 SUBPROVIDER - IRF	2,432,991	41.00
43.00	04300 NURSERY	3,943,822	43.00
44.00	04400 SKILLED NURSING FACILITY	4,655,642	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	18,096,733	50.00
51.00	05100 RECOVERY ROOM	1,352,941	51.00
53.00	05300 ANESTHESIOLOGY	640,504	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,923,925	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,562,625	55.00
57.00	05700 CT SCAN	920,842	57.00
58.00	05800 MRI	705,648	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,826,564	59.00
60.00	06000 LABORATORY	10,704,774	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	807,384	63.00
65.00	06500 RESPIRATORY THERAPY	2,079,713	65.00
66.00	06600 PHYSICAL THERAPY	5,904,281	66.00
69.00	06900 ELECTROCARDIOLOGY	901,159	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	92,066	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,958,642	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,062,755	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	13,573,246	73.00
74.00	07400 RENAL DIALYSIS	571,569	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	76.00
76.97	07697 CARDIAC REHABILITATION	113,015	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699 LI THOTRI PSY	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	659,826	90.00
91.00	09100 EMERGENCY	3,595,545	91.00
91.01	09101 PARTIAL HOSPITALIZATION	339,304	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	156,533,484	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 OTHER	6,323,794	194.00
194.01	07951 LAKESHORE GUEST UNIT	0	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	-1,699,970	201.00
202.00	TOTAL (sum lines 118-201)	161,157,308	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140224

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

Worksheet Non-CMS W
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.01	NONPATIENT TELEPHONES	3	NUMBER OF PHONES	5.01
5.02	DATA PROCESSING	4	TIME SPENT	5.02
5.03	PURCHASING, RECEIVING&STORES	5	SUPPLY EXP ENSE	5.03
5.04	ADMINISTRATIVE	6	INPATIENT REVENUE	5.04
5.05	CASHIERING/ACCTS RECEIVABLE	C	GROSS REVENUE	5.05
5.06	ADMINISTRATION & GENERAL	-1	ACCUM. COST	5.06
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	7	LAUNDRY POUNDS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	8	MEALS SERVED)	10.00
11.00	CAFETERIA	9	MEALS SERVED)	11.00
12.00	MAINTENANCE OF PERSONNEL	10	NUMBER HOUSED	12.00
13.00	NURSING ADMINISTRATION	11	DIRECT NRS G HRS)	13.00
14.00	CENTRAL SERVICES & SUPPLY	12	SUPPLY EXP ENSE	14.00
15.00	PHARMACY	13	COSTED REQUIS)	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	14	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	15	ASSIGNED TIME	19.00
20.00	NURSING SCHOOL	16	ASSIGNED TIME	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	17	ASSIGNED TIME)	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	17	ASSIGNED TIME)	22.00
23.00	PARAMEDICAL PRGM-(SPECIFY)	18	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/26/2015 11:57 am	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		BLDG & FIXT	MVBLE EQUIP					
	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	0	0	0	4.00	
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	5.01	
5.02	00550	DATA PROCESSING	0	0	0	0	5.02	
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	0	0	5.03	
5.04	00570	ADMINITTING	0	0	0	0	5.04	
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	3,078	3,078	5.05	
5.06	00591	ADMINISTRATION & GENERAL	0	0	4,325,010	4,325,010	5.06	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00	
7.00	00700	OPERATION OF PLANT	0	0	455,755	455,755	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	27,948	27,948	8.00	
9.00	00900	HOUSEKEEPING	0	0	493,626	493,626	9.00	
10.00	01000	DIETARY	0	0	470,874	470,874	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00	
13.00	01300	NURSING ADMINISTRATION	0	0	48,459	48,459	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00	
15.00	01500	PHARMACY	0	0	91,033	91,033	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	188,049	188,049	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	73,649	73,649	22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	2,487,658	2,487,658	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	352,017	352,017	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	359,724	359,724	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	149,711	149,711	41.00	
43.00	04300	NURSERY	0	0	107,186	107,186	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	373,661	373,661	44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	979,324	979,324	50.00	
51.00	05100	RECOVERY ROOM	0	0	50,946	50,946	51.00	
53.00	05300	ANESTHESIOLOGY	0	0	21,619	21,619	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	519,161	519,161	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	143,185	143,185	55.00	
57.00	05700	CT SCAN	0	0	38,240	38,240	57.00	
58.00	05800	MRI	0	0	21,053	21,053	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	242,393	242,393	59.00	
60.00	06000	LABORATORY	0	0	268,666	268,666	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	79,140	79,140	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	161,382	161,382	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	936	936	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	13,395	13,395	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00	
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	12,546,878	12,546,878	118.00	
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	269,676	269,676	194.00	
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01	
200.00		Cross Foot Adjustments			0	0	200.00	
201.00		Negative Cost Centers		-1,690,253	0	-1,690,253	201.00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140224

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
202.00 TOTAL (sum lines 118-201)	0	-1,690,253	12,816,554	11,126,301		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/26/2015 11:57 am	
Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING, REC EQUIPMENT&STORES	ADMINING	CASHIERING/ACC TS 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	0					5.01
5.02	00550	DATA PROCESSING	0	0				5.02
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	0			5.03
5.04	00570	ADMINING	0	0	0	0		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	3,078	5.05
5.06	00591	ADMINISTRATION & GENERAL	0	0	0	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	456	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	50	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	69	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	18	41.00
43.00	04300	NURSERY	0	0	0	0	43	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	22	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	396	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	57	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	97	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	164	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	42	55.00
57.00	05700	CT SCAN	0	0	0	0	103	57.00
58.00	05800	MRI	0	0	0	0	64	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	77	59.00
60.00	06000	LABORATORY	0	0	0	0	327	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	18	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	46	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	71	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	81	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	7	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	87	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	426	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	9	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	1	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	12	90.00
91.00	09100	EMERGENCY	0	0	0	0	143	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	4	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	3,078	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	0	3,078	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/26/2015 11:57 am				
Cost Center Description		ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.06	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.01	00540	NONPATIENT TELEPHONES				5.01		
5.02	00550	DATA PROCESSING				5.02		
5.03	00560	PURCHASING, RECEIVING&STORES				5.03		
5.04	00570	ADMITTING				5.04		
5.05	00580	CASHIERING/ACCTS RECEIVABLE				5.05		
5.06	00591	ADMINISTRATION & GENERAL	4,325,010			5.06		
6.00	00600	MAINTENANCE & REPAIRS	30,397	30,397		6.00		
7.00	00700	OPERATION OF PLANT	194,770	1,632	652,157	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	27,441	100	2,269	57,758	8.00	
9.00	00900	HOUSEKEEPING	90,128	1,768	40,076	40	625,638	9.00
10.00	01000	DIETARY	83,187	1,686	38,229	0	39,221	10.00
11.00	01100	CAFETERIA	17,287	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	70,432	174	3,934	0	4,036	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	25	0	14.00
15.00	01500	PHARMACY	92,684	326	7,391	0	7,583	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,100	673	15,267	0	15,664	16.00
17.00	01700	SOCIAL SERVICE	51,832	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	258,134	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	236,697	264	5,979	0	6,135	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	701,165	8,909	201,970	27,151	207,208	30.00
31.00	03100	INTENSIVE CARE UNIT	116,712	1,261	28,579	2,591	29,321	31.00
40.00	04000	SUBPROVIDER - I/PF	135,824	1,288	29,205	1,985	29,963	40.00
41.00	04100	SUBPROVIDER - I/RF	40,134	536	12,155	2,672	12,470	41.00
43.00	04300	NURSERY	78,998	384	8,702	0	8,928	43.00
44.00	04400	SKILLED NURSING FACILITY	72,416	1,338	30,337	4,314	31,124	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	364,723	3,507	79,509	7,537	81,572	50.00
51.00	05100	RECOVERY ROOM	25,850	182	4,136	1,264	4,244	51.00
53.00	05300	ANESTHESIOLOGY	12,338	77	1,755	0	1,801	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,390	1,859	42,149	3,696	43,243	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	52,509	513	11,625	713	11,927	55.00
57.00	05700	CT SCAN	17,992	137	3,105	232	3,185	57.00
58.00	05800	MRI	14,451	75	1,709	0	1,754	58.00
59.00	05900	CARDIAC CATHETERIZATION	51,388	868	19,679	1,329	20,190	59.00
60.00	06000	LABORATORY	233,883	962	21,812	750	22,378	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	18,644	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	44,359	283	6,425	0	6,592	65.00
66.00	06600	PHYSICAL THERAPY	129,889	578	13,102	211	13,442	66.00
69.00	06900	ELECTROCARDIOLOGY	19,297	0	0	442	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,972	3	76	23	78	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	230,473	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	164,290	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,122	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	13,269	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,399	0	0	63	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	13,973	48	1,088	902	1,116	90.00
91.00	09100	EMERGENCY	76,646	0	0	1,736	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	7,838	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,191,033	29,431	630,263	57,676	603,175	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	133,977	966	21,894	82	22,463	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,325,010	30,397	652,157	57,758	625,638	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/26/2015 11:57 am	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	633,197					10.00
11.00	01100	CAFETERIA	0	17,287				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	306	0	127,341		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	25	14.00
15.00	01500	PHARMACY	0	502	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	263	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	279	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	2,898	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	433,258	4,387	0	60,132	0	30.00
31.00	03100	INTENSIVE CARE UNIT	16,758	575	0	10,969	0	31.00
40.00	04000	SUBPROVIDER - I PF	93,114	770	0	7,689	0	40.00
41.00	04100	SUBPROVIDER - I RF	26,134	311	0	4,216	0	41.00
43.00	04300	NURSERY	0	379	0	6,916	0	43.00
44.00	04400	SKILLED NURSING FACILITY	63,933	477	0	5,909	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,719	0	11,734	0	50.00
51.00	05100	RECOVERY ROOM	0	207	0	3,396	0	51.00
53.00	05300	ANESTHESIOLOGY	0	47	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	706	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	236	0	576	0	55.00
57.00	05700	CT SCAN	0	69	0	5	0	57.00
58.00	05800	MRI	0	89	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	365	0	4,264	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	335	0	6	0	65.00
66.00	06600	PHYSICAL THERAPY	0	610	0	32	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	151	0	83	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	17	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	18	0	327	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	89	0	372	0	90.00
91.00	09100	EMERGENCY	0	501	0	6,763	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	53	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	633,197	16,359	0	123,389	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	928	0	3,952	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	25	201.00
202.00		TOTAL (sum lines 118-201)	633,197	17,287	0	127,341	25	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/26/2015 11:57 am	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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&STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	199,519					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	268,016				16.00
17.00	01700	SOCIAL SERVICE	0	0	52,111			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	39,105	31,515			30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,295	2,636			31.00
40.00	04000	SUBPROVIDER - I PF	0	5,922	7,298			40.00
41.00	04100	SUBPROVIDER - I RF	0	1,525	2,137			41.00
43.00	04300	NURSERY	0	3,729	4,011			43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,885	4,514			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33,937	0			50.00
51.00	05100	RECOVERY ROOM	0	4,875	0			51.00
53.00	05300	ANESTHESIOLOGY	0	8,352	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,063	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,616	0			55.00
57.00	05700	CT SCAN	0	8,802	0			57.00
58.00	05800	MRI	0	5,480	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,608	0			59.00
60.00	06000	LABORATORY	0	28,019	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,505	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	3,939	0			65.00
66.00	06600	PHYSICAL THERAPY	0	6,048	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,917	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	587	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,120	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,439	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	199,519	40,748	0			73.00
74.00	07400	RENAL DIALYSIS	0	729	0			74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	91	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,041	0			90.00
91.00	09100	EMERGENCY	0	12,271	0			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	368	0			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	199,519	268,016	52,111	0	0	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0			194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	199,519	268,016	52,111	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/26/2015 11:57 am
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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
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&STORES				5.03
5.04 00570	ADMINITTING				5.04
5.05 00580	CASHIERING/ACCTS RECEIVABLE				5.05
5.06 00591	ADMINISTRATION & GENERAL				5.06
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	261,032			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		322,724		22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS			4,202,914	0 30.00
31.00 03100	INTENSIVE CARE UNIT			565,764	0 31.00
40.00 04000	SUBPROVIDER - I PF			672,851	0 40.00
41.00 04100	SUBPROVIDER - I RF			252,019	0 41.00
43.00 04300	NURSERY			219,276	0 43.00
44.00 04400	SKILLED NURSING FACILITY			589,930	0 44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM			1,563,958	0 50.00
51.00 05100	RECOVERY ROOM			95,157	0 51.00
53.00 05300	ANESTHESIOLOGY			46,086	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC			760,431	0 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC			224,942	0 55.00
57.00 05700	CT SCAN			71,870	0 57.00
58.00 05800	MRI			44,675	0 58.00
59.00 05900	CARDIAC CATHETERIZATION			347,161	0 59.00
60.00 06000	LABORATORY			576,797	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0 62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.			20,167	0 63.00
65.00 06500	RESPIRATORY THERAPY			141,125	0 65.00
66.00 06600	PHYSICAL THERAPY			325,365	0 66.00
69.00 06900	ELECTROCARDIOLOGY			26,971	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY			3,699	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT			246,781	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS			171,816	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS			453,815	0 73.00
74.00 07400	RENAL DIALYSIS			14,007	0 74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER			0	0 76.00
76.97 07697	CARDIAC REHABILITATION			2,899	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY			0	0 76.98
76.99 07699	LITHOTRIPSY			0	0 76.99
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC			32,036	0 90.00
91.00 09100	EMERGENCY			98,060	0 91.00
91.01 09101	PARTIAL HOSPITALIZATION			8,263	0 91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0 92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	11,778,835 0 118.00
NONREIMBURSABLE COST CENTERS					
194.00 07950	OTHER			453,938	0 194.00
194.01 07951	LAKESHORE GUEST UNIT			0	0 194.01
200.00	Cross Foot Adjustments	261,032	322,724	0	583,756 0 200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/26/2015 11: 57 am			
		INTERNS & RESI DENTS		PARAMED ED PRGM	Subtotal	Intern & Resi dents Cost & Post Stepdown Adj ustments			
Cost Center Description		SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV					21.00	22.00
201.00	Negative Cost Centers	0	0	0			-1,690,228	0	201.00
202.00	TOTAL (sum lines 118-201)	261,032	322,724	0			11,126,301	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/26/2015 11:57 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	5.03
5.04	00570	ADMINISTRATIVE	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	5.05
5.06	00591	ADMINISTRATION & GENERAL	5.06
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LI THOTRI PSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
91.01	09101	PARTIAL HOSPITALIZATION	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER	194.00
194.01	07951	LAKESHORE GUEST UNIT	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1

Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	520,502				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		520,502			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	75,624,380		4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	1,113	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	100
5.03	00560	PURCHASING, RECEIVING&STORES	0	0	0	18	0
5.04	00570	ADMINISTRATIVE	0	0	0	32	0
5.05	00580	CASHIERING/ACCTS RECEIVABLE	125	125	0	50	0
5.06	00591	ADMINISTRATION & GENERAL	175,646	175,646	6,011,202	136	100
6.00	00600	MAINTENANCE & REPAIRS	0	0	418,459	0	0
7.00	00700	OPERATION OF PLANT	18,509	18,509	677,970	46	0
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	0	4	0
9.00	00900	HOUSEKEEPING	20,047	20,047	1,253,079	6	0
10.00	01000	DIETARY	19,123	19,123	883,899	8	0
11.00	01100	CAFETERIA	0	0	628,802	12	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,968	1,968	1,792,670	48	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	5	0
15.00	01500	PHARMACY	3,697	3,697	2,544,122	20	0
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	753,046	38	0
17.00	01700	SOCIAL SERVICE	0	0	1,396,369	15	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	6,968,525	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,991	2,991	4,822,281	53	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	101,028	101,028	15,918,814	170	0
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	2,327,836	39	0
40.00	04000	SUBPROVIDER - I PF	14,609	14,609	2,736,603	0	0
41.00	04100	SUBPROVIDER - I RF	6,080	6,080	926,286	23	0
43.00	04300	NURSERY	4,353	4,353	1,912,123	8	0
44.00	04400	SKILLED NURSING FACILITY	15,175	15,175	1,532,288	12	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,772	39,772	5,136,319	82	0
51.00	05100	RECOVERY ROOM	2,069	2,069	611,432	0	0
53.00	05300	ANESTHESIOLOGY	878	878	125,716	2	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,084	21,084	2,498,674	81	0
55.00	05500	RADIOLOGY-THERAPEUTIC	5,815	5,815	1,011,622	0	0
57.00	05700	CT SCAN	1,553	1,553	315,917	0	0
58.00	05800	MRI	855	855	283,103	0	0
59.00	05900	CARDIAC CATHETERIZATION	9,844	9,844	1,026,442	0	0
60.00	06000	LABORATORY	10,911	10,911	0	58	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	1,014,094	14	0
66.00	06600	PHYSICAL THERAPY	6,554	6,554	2,945,416	28	0
69.00	06900	ELECTROCARDIOLOGY	0	0	397,929	16	0
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	51,769	13	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	6	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	67,279	3	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	544	544	339,154	42	0
91.00	09100	EMERGENCY	0	0	1,817,844	25	0
91.01	09101	PARTIAL HOSPITALIZATION	0	0	220,141	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	509,550	509,550	71,367,225	1,113	100
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	10,952	10,952	4,257,155	0	0
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1

Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	-1,690,253	12,816,554	17,421,846	20,535	2,860,138	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	24.623448	0.230373	18.450135	28,601.380000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet B-1	
Date/Time Prepared: 5/26/2015 11:57 am							
Cost Center Description	PURCHASING, RECEIVING & STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & 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 & STORES	9,185,398					5.03
5.04 00570	ADMITTING	0	473,097,497				5.04
5.05 00580	CASHIERING/ACCTS RECEIVABLE	0	0	782,508,898			5.05
5.06 00591	ADMINISTRATION & GENERAL	277,625	0	0	-40,528,374	143,656,794	5.06
6.00 00600	MAINTENANCE & REPAIRS	3,188	0	0	0	1,009,625	6.00
7.00 00700	OPERATION OF PLANT	2,684	0	0	0	6,469,258	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	911,464	8.00
9.00 00900	HOUSEKEEPING	111,072	0	0	0	2,993,591	9.00
10.00 01000	DIETARY	161,999	0	0	0	2,763,038	10.00
11.00 01100	CAFETERIA	0	0	0	0	574,201	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	15,828	0	0	0	2,339,406	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	21,995	0	0	10,235	0	14.00
15.00 01500	PHARMACY	36,096	0	0	0	3,078,474	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	40,981	0	0	0	1,597,634	16.00
17.00 01700	SOCIAL SERVICE	1,417	0	0	0	1,721,583	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	8,573,885	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	235,413	0	0	0	7,861,874	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	217,137	103,041,204	114,009,207	0	23,291,287	30.00
31.00 03100	INTENSIVE CARE UNIT	7,272	12,522,455	12,522,455	0	3,876,580	31.00
40.00 04000	SUBPROVIDER - I/PF	30,012	17,262,094	17,265,908	0	4,511,380	40.00
41.00 04100	SUBPROVIDER - I/RF	10,021	4,445,736	4,445,736	0	1,333,030	41.00
43.00 04300	NURSERY	17,786	10,867,812	10,872,951	0	2,623,915	43.00
44.00 04400	SKILLED NURSING FACILITY	24,325	5,495,583	5,495,583	0	2,405,297	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	464,701	30,461,943	98,941,456	0	12,114,212	50.00
51.00 05100	RECOVERY ROOM	1,727	4,523,224	14,213,548	0	858,593	51.00
53.00 05300	ANESTHESIOLOGY	1,313	8,132,077	24,348,940	0	409,793	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	30,407	13,694,577	40,999,429	0	4,496,965	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	23,801	434,539	10,542,993	0	1,744,083	55.00
57.00 05700	CT SCAN	8,453	9,339,953	25,660,403	0	597,587	57.00
58.00 05800	MRI	883	5,477,412	15,977,713	0	479,999	58.00
59.00 05900	CARDIAC CATHETERIZATION	58,257	10,924,441	19,266,108	0	1,706,848	59.00
60.00 06000	LABORATORY	0	51,969,820	81,687,107	0	7,768,408	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	3,564,851	4,388,115	0	619,250	63.00
65.00 06500	RESPIRATORY THERAPY	3,066	10,770,389	11,483,680	0	1,473,371	65.00
66.00 06600	PHYSICAL THERAPY	20,442	9,630,008	17,631,408	0	4,314,232	66.00
69.00 06900	ELECTROCARDIOLOGY	4,361	9,469,234	20,166,901	0	640,959	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,808	477,477	1,710,550	0	65,499	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,274,150	27,644,374	46,998,487	0	7,655,124	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,912,769	21,688,629	0	5,456,877	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	95,801,015	119,912,994	0	7,078,816	73.00
74.00 07400	RENAL DIALYSIS	0	2,017,467	2,126,772	0	440,723	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	537	12,007	266,389	0	79,693	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	1,069	234,727	3,036,335	0	464,098	90.00
91.00 09100	EMERGENCY	35,114	12,970,309	35,775,015	0	2,545,781	91.00
91.01 09101	PARTIAL HOSPITALIZATION	593	0	1,074,086	0	260,324	91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,146,533	473,097,497	782,508,898	-40,518,139	139,206,757	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950	OTHER	38,865	0	0	0	4,450,037	194.00
194.01 07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	272,608	649	2,747,897		40,528,374	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1

Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		PURCHASING, RECEIVING & STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.029678	0.000001	0.003512		0.282119	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	3,078		4,325,010	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000004		0.030107	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
6.00	00600	344,731					6.00
7.00	00700	18,509	326,222				7.00
8.00	00800	1,135	1,135	1,989,392			8.00
9.00	00900	20,047	20,047	1,387	305,040		9.00
10.00	01000	19,123	19,123	0	19,123	150,047	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	1,968	1,968	0	1,968	0	13.00
14.00	01400	0	0	857	0	0	14.00
15.00	01500	3,697	3,697	0	3,697	0	15.00
16.00	01600	7,637	7,637	0	7,637	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	2,991	2,991	0	2,991	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	101,028	101,028	935,160	101,028	102,668	30.00
31.00	03100	14,296	14,296	89,252	14,296	3,971	31.00
40.00	04000	14,609	14,609	68,364	14,609	22,065	40.00
41.00	04100	6,080	6,080	92,018	6,080	6,193	41.00
43.00	04300	4,353	4,353	0	4,353	0	43.00
44.00	04400	15,175	15,175	148,598	15,175	15,150	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	39,772	39,772	259,610	39,772	0	50.00
51.00	05100	2,069	2,069	43,552	2,069	0	51.00
53.00	05300	878	878	0	878	0	53.00
54.00	05400	21,084	21,084	127,315	21,084	0	54.00
55.00	05500	5,815	5,815	24,566	5,815	0	55.00
57.00	05700	1,553	1,553	8,008	1,553	0	57.00
58.00	05800	855	855	0	855	0	58.00
59.00	05900	9,844	9,844	45,761	9,844	0	59.00
60.00	06000	10,911	10,911	25,819	10,911	0	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	0	0	0	0	0	63.00
65.00	06500	3,214	3,214	3	3,214	0	65.00
66.00	06600	6,554	6,554	7,255	6,554	0	66.00
69.00	06900	0	0	15,241	0	0	69.00
70.00	07000	38	38	778	38	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	0	0	2,164	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	544	544	31,059	544	0	90.00
91.00	09100	0	0	59,786	0	0	91.00
91.01	09101	0	0	0	0	0	91.01
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		333,779	315,270	1,986,553	294,088	150,047	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	10,952	10,952	2,839	10,952	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		1,294,459	8,363,860	1,201,967	4,428,230	4,382,243	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1

Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	3.754983	25.638553	0.604188	14.516883	29.205802	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	30,397	652,157	57,758	625,638	633,197	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.088176	1.999120	0.029033	2.051003	4.219991	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS)	CENTRAL SERVICES & SUPPLY (SUPPLY EXP ENSE)	PHARMACY (COSTED REQ UIS)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	106,340					11.00
12.00	01200	0	0				12.00
13.00	01300	1,883	0	782,724			13.00
14.00	01400	0	0	0	12,654,845		14.00
15.00	01500	3,085	0	0	0	6,657,859	15.00
16.00	01600	1,618	0	0	0	0	16.00
17.00	01700	1,716	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	17,830	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	26,992	0	369,611	0	0	30.00
31.00	03100	3,535	0	67,423	0	0	31.00
40.00	04000	4,736	0	47,259	0	0	40.00
41.00	04100	1,915	0	25,914	0	0	41.00
43.00	04300	2,329	0	42,509	0	0	43.00
44.00	04400	2,937	0	36,323	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	10,575	0	72,124	0	0	50.00
51.00	05100	1,272	0	20,875	0	0	51.00
53.00	05300	291	0	0	0	0	53.00
54.00	05400	4,341	0	0	0	0	54.00
55.00	05500	1,449	0	3,541	0	0	55.00
57.00	05700	427	0	33	0	0	57.00
58.00	05800	546	0	0	0	0	58.00
59.00	05900	2,244	0	26,211	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	0	0	0	0	0	63.00
65.00	06500	2,059	0	35	0	0	65.00
66.00	06600	3,755	0	198	0	0	66.00
69.00	06900	926	0	511	0	0	69.00
70.00	07000	103	0	0	0	0	70.00
71.00	07100	0	0	0	7,274,150	0	71.00
72.00	07200	0	0	0	5,380,695	0	72.00
73.00	07300	0	0	0	0	6,657,859	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	109	0	2,011	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	549	0	2,286	0	0	90.00
91.00	09100	3,083	0	41,570	0	0	91.00
91.01	09101	325	0	0	0	0	91.01
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		100,630	0	758,434	12,654,845	6,657,859	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	5,710	0	24,290	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1

Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS G HRS)	CENTRAL SERVICES & SUPPLY (SUPPLY EXP ENSE)	PHARMACY (COSTED REQ UIS)	
		11.00	12.00	13.00	14.00	15.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	736,194	0	3,098,849	-9,717	4,130,665	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.923021	0.000000	3.959057	0.000000	0.620419	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	17,287	0	127,341	25	199,519	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.162563	0.000000	0.162690	0.000002	0.029967	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
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&STORES						5.03
5.04 00570 ADMINITTING						5.04
5.05 00580 CASHIERING/ACCTS RECEIVABLE						5.05
5.06 00591 ADMINISTRATION & GENERAL						5.06
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	782,508,898					16.00
17.00 01700 SOCIAL SERVICE	0	63,025				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			9,394	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	114,009,207	38,117		0	6,478	30.00
31.00 03100 INTENSIVE CARE UNIT	12,522,455	3,188		0	1,552	31.00
40.00 04000 SUBPROVIDER - I PF	17,265,908	8,826		0	0	40.00
41.00 04100 SUBPROVIDER - I RF	4,445,736	2,584		0	0	41.00
43.00 04300 NURSERY	10,872,951	4,851		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	5,495,583	5,459		0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	98,941,456	0	0	0	376	50.00
51.00 05100 RECOVERY ROOM	14,213,548	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	24,348,940	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	40,999,429	0	0	0	204	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	10,542,993	0	0	0	0	55.00
57.00 05700 CT SCAN	25,660,403	0	0	0	0	57.00
58.00 05800 MRI	15,977,713	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	19,266,108	0	0	0	0	59.00
60.00 06000 LABORATORY	81,687,107	0	0	0	82	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	4,388,115	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	11,483,680	0	0	0	163	65.00
66.00 06600 PHYSICAL THERAPY	17,631,408	0	0	0	163	66.00
69.00 06900 ELECTROCARDIOLOGY	20,166,901	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1,710,550	0	0	0	376	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46,998,487	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	21,688,629	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	119,912,994	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	2,126,772	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	266,389	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	3,036,335	0	0	0	0	90.00
91.00 09100 EMERGENCY	35,775,015	0	0	0	0	91.00
91.01 09101 PARTIAL HOSPITALIZATION	1,074,086	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	782,508,898	63,025	0	9,394	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950 OTHER	0	0	0	0	0	194.00
194.01 07951 LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1

Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
		16.00	17.00	19.00	20.00	21.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,394,902	2,219,154	0	0	11,116,178	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.003061	35.210694	0.000000	0.000000	1,183.327443	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	268,016	52,111	0	0	261,032	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000343	0.826831	0.000000	0.000000	27.787098	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)		
		SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
		22.00	23.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING, RECEIVING&STORES			5.03
5.04	00570	ADMINITING			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATION & GENERAL			5.06
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	9,394		22.00
23.00	02300	PARAMED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,478	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,552	0	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	376	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	204	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	82	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	163	0	65.00
66.00	06600	PHYSICAL THERAPY	163	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	376	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,394	0	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		Cross Foot Adjustments			200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

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

Worksheet B-1
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
		SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		22.00	23.00	
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	10,211,194	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1,086.991058	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	322,724	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	34.354269	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		41,203,245	233,609	41,436,854	30.00
31.00	03100 INTENSIVE CARE UNIT		6,209,869	0	6,209,869	31.00
40.00	04000 SUBPROVIDER - I/PF		7,694,854	0	7,694,854	40.00
41.00	04100 SUBPROVIDER - I/RF		2,432,991	0	2,432,991	41.00
43.00	04300 NURSERY		3,943,822	0	3,943,822	43.00
44.00	04400 SKILLED NURSING FACILITY		4,655,642	0	4,655,642	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		18,096,733	0	18,096,733	50.00
51.00	05100 RECOVERY ROOM		1,352,941	0	1,352,941	51.00
53.00	05300 ANESTHESIOLOGY		640,504	0	640,504	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,923,925	0	6,923,925	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		2,562,625	0	2,562,625	55.00
57.00	05700 CT SCAN		920,842	0	920,842	57.00
58.00	05800 MRI		705,648	0	705,648	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,826,564	0	2,826,564	59.00
60.00	06000 LABORATORY		10,704,774	0	10,704,774	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		807,384	0	807,384	63.00
65.00	06500 RESPIRATORY THERAPY	0	2,079,713	0	2,079,713	65.00
66.00	06600 PHYSICAL THERAPY	0	5,904,281	0	5,904,281	66.00
69.00	06900 ELECTROCARDIOLOGY		901,159	0	901,159	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		92,066	0	92,066	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		9,958,642	0	9,958,642	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,062,755	0	7,062,755	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		13,573,246	0	13,573,246	73.00
74.00	07400 RENAL DIALYSIS		571,569	0	571,569	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER		0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION		113,015	0	113,015	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY		0	0	0	76.98
76.99	07699 LI THOTRI PSY		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		659,826	0	659,826	90.00
91.00	09100 EMERGENCY		3,595,545	0	3,595,545	91.00
91.01	09101 PARTIAL HOSPITALIZATION		339,304	0	339,304	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,963,711		1,963,711	92.00
200.00	Subtotal (see instructions)	0	158,497,195	233,609	158,730,804	200.00
201.00	Less Observation Beds		1,963,711		1,963,711	201.00
202.00	Total (see instructions)	0	156,533,484	233,609	156,767,093	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/26/2015 11:57 am
		Title XVII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	105,242,146		105,242,146	30.00
31.00	03100	INTENSIVE CARE UNIT	12,522,455		12,522,455	31.00
40.00	04000	SUBPROVIDER - I/PF	17,265,908		17,265,908	40.00
41.00	04100	SUBPROVIDER - I/RP	4,445,736		4,445,736	41.00
43.00	04300	NURSERY	10,872,951		10,872,951	43.00
44.00	04400	SKILLED NURSING FACILITY	5,495,583		5,495,583	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,461,943	68,479,513	98,941,456	50.00
51.00	05100	RECOVERY ROOM	4,523,224	9,690,324	14,213,548	51.00
53.00	05300	ANESTHESIOLOGY	8,132,077	16,216,863	24,348,940	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,694,577	27,304,852	40,999,429	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	434,539	10,108,454	10,542,993	55.00
57.00	05700	CT SCAN	9,339,953	16,320,450	25,660,403	57.00
58.00	05800	MRI	5,477,412	10,500,301	15,977,713	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,924,441	8,341,667	19,266,108	59.00
60.00	06000	LABORATORY	51,969,820	29,717,287	81,687,107	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,564,851	823,264	4,388,115	63.00
65.00	06500	RESPIRATORY THERAPY	10,770,389	713,291	11,483,680	65.00
66.00	06600	PHYSICAL THERAPY	9,630,008	8,001,400	17,631,408	66.00
69.00	06900	ELECTROCARDIOLOGY	9,469,234	10,697,667	20,166,901	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	477,477	1,233,073	1,710,550	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,644,374	19,354,113	46,998,487	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,912,769	9,775,860	21,688,629	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,801,015	24,111,979	119,912,994	73.00
74.00	07400	RENAL DIALYSIS	2,017,467	109,305	2,126,772	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	12,007	254,382	266,389	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	234,727	2,801,608	3,036,335	90.00
91.00	09100	EMERGENCY	12,970,309	22,804,706	35,775,015	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	1,074,086	1,074,086	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,301,177	7,465,884	8,767,061	92.00
200.00		Subtotal (see instructions)	476,608,569	305,900,329	782,508,898	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	476,608,569	305,900,329	782,508,898	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/26/2015 11:57 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.182903		50.00
51.00	05100 RECOVERY ROOM	0.095187		51.00
53.00	05300 ANESTHESIOLOGY	0.026305		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168879		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.243064		55.00
57.00	05700 CT SCAN	0.035886		57.00
58.00	05800 MRI	0.044165		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.146712		59.00
60.00	06000 LABORATORY	0.131046		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.183993		63.00
65.00	06500 RESPIRATORY THERAPY	0.181102		65.00
66.00	06600 PHYSICAL THERAPY	0.334873		66.00
69.00	06900 ELECTROCARDIOLOGY	0.044685		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.053822		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.325643		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113192		73.00
74.00	07400 RENAL DIALYSIS	0.268750		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.424248		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.217310		90.00
91.00	09100 EMERGENCY	0.100504		91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.315900		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.223987		92.00
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: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/26/2015 11:57 am
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
			1.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	41,203,245		41,203,245	233,609	41,436,854	30.00
31.00 03100 INTENSIVE CARE UNIT	6,209,869		6,209,869	0	6,209,869	31.00
40.00 04000 SUBPROVIDER - I/PF	7,694,854		7,694,854	0	7,694,854	40.00
41.00 04100 SUBPROVIDER - I/RF	2,432,991		2,432,991	0	2,432,991	41.00
43.00 04300 NURSERY	3,943,822		3,943,822	0	3,943,822	43.00
44.00 04400 SKILLED NURSING FACILITY	4,655,642		4,655,642	0	4,655,642	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	18,096,733		18,096,733	0	18,096,733	50.00
51.00 05100 RECOVERY ROOM	1,352,941		1,352,941	0	1,352,941	51.00
53.00 05300 ANESTHESIOLOGY	640,504		640,504	0	640,504	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	6,923,925		6,923,925	0	6,923,925	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	2,562,625		2,562,625	0	2,562,625	55.00
57.00 05700 CT SCAN	920,842		920,842	0	920,842	57.00
58.00 05800 MRI	705,648		705,648	0	705,648	58.00
59.00 05900 CARDIAC CATHETERIZATION	2,826,564		2,826,564	0	2,826,564	59.00
60.00 06000 LABORATORY	10,704,774		10,704,774	0	10,704,774	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	807,384		807,384	0	807,384	63.00
65.00 06500 RESPIRATORY THERAPY	2,079,713	0	2,079,713	0	2,079,713	65.00
66.00 06600 PHYSICAL THERAPY	5,904,281	0	5,904,281	0	5,904,281	66.00
69.00 06900 ELECTROCARDIOLOGY	901,159		901,159	0	901,159	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	92,066		92,066	0	92,066	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,958,642		9,958,642	0	9,958,642	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	7,062,755		7,062,755	0	7,062,755	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	13,573,246		13,573,246	0	13,573,246	73.00
74.00 07400 RENAL DIALYSIS	571,569		571,569	0	571,569	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	113,015		113,015	0	113,015	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99 07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	659,826		659,826	0	659,826	90.00
91.00 09100 EMERGENCY	3,595,545		3,595,545	0	3,595,545	91.00
91.01 09101 PARTIAL HOSPITALIZATION	339,304		339,304	0	339,304	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,963,711		1,963,711		1,963,711	92.00
200.00 Subtotal (see instructions)	158,497,195	0	158,497,195	233,609	158,730,804	200.00
201.00 Less Observation Beds	1,963,711		1,963,711		1,963,711	201.00
202.00 Total (see instructions)	156,533,484	0	156,533,484	233,609	156,767,093	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/26/2015 11:57 am
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		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	105,242,146		105,242,146		30.00
31.00	03100	INTENSIVE CARE UNIT	12,522,455		12,522,455		31.00
40.00	04000	SUBPROVIDER - I/PF	17,265,908		17,265,908		40.00
41.00	04100	SUBPROVIDER - I/RP	4,445,736		4,445,736		41.00
43.00	04300	NURSERY	10,872,951		10,872,951		43.00
44.00	04400	SKILLED NURSING FACILITY	5,495,583		5,495,583		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	30,461,943	68,479,513	98,941,456	0.182903	50.00
51.00	05100	RECOVERY ROOM	4,523,224	9,690,324	14,213,548	0.095187	51.00
53.00	05300	ANESTHESIOLOGY	8,132,077	16,216,863	24,348,940	0.026305	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,694,577	27,304,852	40,999,429	0.168879	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	434,539	10,108,454	10,542,993	0.243064	55.00
57.00	05700	CT SCAN	9,339,953	16,320,450	25,660,403	0.035886	57.00
58.00	05800	MRI	5,477,412	10,500,301	15,977,713	0.044165	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,924,441	8,341,667	19,266,108	0.146712	59.00
60.00	06000	LABORATORY	51,969,820	29,717,287	81,687,107	0.131046	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,564,851	823,264	4,388,115	0.183993	63.00
65.00	06500	RESPIRATORY THERAPY	10,770,389	713,291	11,483,680	0.181102	65.00
66.00	06600	PHYSICAL THERAPY	9,630,008	8,001,400	17,631,408	0.334873	66.00
69.00	06900	ELECTROCARDIOLOGY	9,469,234	10,697,667	20,166,901	0.044685	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	477,477	1,233,073	1,710,550	0.053822	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,644,374	19,354,113	46,998,487	0.211893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,912,769	9,775,860	21,688,629	0.325643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,801,015	24,111,979	119,912,994	0.113192	73.00
74.00	07400	RENAL DIALYSIS	2,017,467	109,305	2,126,772	0.268750	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	12,007	254,382	266,389	0.424248	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	234,727	2,801,608	3,036,335	0.217310	90.00
91.00	09100	EMERGENCY	12,970,309	22,804,706	35,775,015	0.100504	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	1,074,086	1,074,086	0.315900	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,301,177	7,465,884	8,767,061	0.223987	92.00
200.00		Subtotal (see instructions)	476,608,569	305,900,329	782,508,898		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	476,608,569	305,900,329	782,508,898		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/26/2015 11:57 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
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
51.00	05100 RECOVERY ROOM	0.000000		51.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.000000		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I Date/Time Prepared: 5/26/2015 11:57 am
Title XVIII		Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	4,202,914	0	4,202,914	43,110	97.49	30.00
31.00	INTENSIVE CARE UNIT	565,764	0	565,764	3,177	178.08	31.00
40.00	SUBPROVIDER - IPF	672,851	0	672,851	8,826	76.24	40.00
41.00	SUBPROVIDER - IRF	252,019	0	252,019	2,477	101.74	41.00
43.00	NURSERY	219,276		219,276	4,863	45.09	43.00
44.00	SKILLED NURSING FACILITY	589,930		589,930	6,060	97.35	44.00
200.00	Total (lines 30-199)	6,502,754		6,502,754	68,513		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	18,148	1,769,249				
31.00	INTENSIVE CARE UNIT	1,835	326,777				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	1,597	162,479				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	4,506	438,659				
200.00	Total (lines 30-199)	26,086	2,697,164				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/26/2015 11:57 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,563,958	98,941,456	0.015807	11,901,926	188,134	50.00
51.00	05100	RECOVERY ROOM	95,157	14,213,548	0.006695	1,708,818	11,441	51.00
53.00	05300	ANESTHESIOLOGY	46,086	24,348,940	0.001893	2,771,100	5,246	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	760,431	40,999,429	0.018547	6,463,731	119,883	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	224,942	10,542,993	0.021336	259,513	5,537	55.00
57.00	05700	CT SCAN	71,870	25,660,403	0.002801	4,475,698	12,536	57.00
58.00	05800	MRI	44,675	15,977,713	0.002796	1,964,027	5,491	58.00
59.00	05900	CARDIAC CATHETERIZATION	347,161	19,266,108	0.018019	5,396,398	97,238	59.00
60.00	06000	LABORATORY	576,797	81,687,107	0.007061	22,449,872	158,519	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,167	4,388,115	0.004596	2,018,705	9,278	63.00
65.00	06500	RESPIRATORY THERAPY	141,125	11,483,680	0.012289	5,478,119	67,321	65.00
66.00	06600	PHYSICAL THERAPY	325,365	17,631,408	0.018454	2,064,914	38,106	66.00
69.00	06900	ELECTROCARDIOLOGY	26,971	20,166,901	0.001337	4,939,622	6,604	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,699	1,710,550	0.002162	211,389	457	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	246,781	46,998,487	0.005251	12,140,815	63,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	171,816	21,688,629	0.007922	5,167,948	40,940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	453,815	119,912,994	0.003785	31,930,877	120,858	73.00
74.00	07400	RENAL DIALYSIS	14,007	2,126,772	0.006586	1,369,205	9,018	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,899	266,389	0.010883	6,506	71	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	32,036	3,036,335	0.010551	118,629	1,252	90.00
91.00	09100	EMERGENCY	98,060	35,775,015	0.002741	6,629,577	18,172	91.00
91.01	09101	PARTIAL HOSPITALIZATION	8,263	1,074,086	0.007693	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	199,177	8,767,061	0.022719	817,154	18,565	92.00
200.00		Total (lines 50-199)	5,475,258	626,664,119		130,284,543	998,418	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part III Date/Time Prepared: 5/26/2015 11:57 am
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Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,110	0.00	18,148	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,177	0.00	1,835	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	8,826	0.00	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,477	0.00	1,597	0	0	41.00
43.00	04300	NURSERY	4,863	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,060	0.00	4,506	0	0	44.00
200.00		Total (lines 30-199)	68,513		26,086	0	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
41.00	04100	SUBPROVIDER - IRF	0	0				41.00
43.00	04300	NURSERY	0	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
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Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Inpatient Program Charges	
			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)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	98,941,456	0.000000	0.000000	11,901,926	50.00
51.00	05100	RECOVERY ROOM	0	14,213,548	0.000000	0.000000	1,708,818	51.00
53.00	05300	ANESTHESIOLOGY	0	24,348,940	0.000000	0.000000	2,771,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,999,429	0.000000	0.000000	6,463,731	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,542,993	0.000000	0.000000	259,513	55.00
57.00	05700	CT SCAN	0	25,660,403	0.000000	0.000000	4,475,698	57.00
58.00	05800	MRI	0	15,977,713	0.000000	0.000000	1,964,027	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,266,108	0.000000	0.000000	5,396,398	59.00
60.00	06000	LABORATORY	0	81,687,107	0.000000	0.000000	22,449,872	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,388,115	0.000000	0.000000	2,018,705	63.00
65.00	06500	RESPIRATORY THERAPY	0	11,483,680	0.000000	0.000000	5,478,119	65.00
66.00	06600	PHYSICAL THERAPY	0	17,631,408	0.000000	0.000000	2,064,914	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,166,901	0.000000	0.000000	4,939,622	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,710,550	0.000000	0.000000	211,389	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,998,487	0.000000	0.000000	12,140,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,688,629	0.000000	0.000000	5,167,948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	119,912,994	0.000000	0.000000	31,930,877	73.00
74.00	07400	RENAL DIALYSIS	0	2,126,772	0.000000	0.000000	1,369,205	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	266,389	0.000000	0.000000	6,506	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,036,335	0.000000	0.000000	118,629	90.00
91.00	09100	EMERGENCY	0	35,775,015	0.000000	0.000000	6,629,577	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	1,074,086	0.000000	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,767,061	0.000000	0.000000	817,154	92.00
200.00		Total (lines 50-199)	0	626,664,119			130,284,543	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
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Cost Center Description		Title XVII			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	13,752,069	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	1,439,655	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	3,337,569	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,242,687	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	3,295,327	0	0	0	55.00
57.00	05700 CT SCAN	0	4,850,759	0	0	0	57.00
58.00	05800 MRI	0	2,689,245	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	4,049,709	0	0	0	59.00
60.00	06000 LABORATORY	0	6,774,224	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	213,048	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	228,081	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	539,852	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	3,608,879	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	321,790	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,297,584	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,813,332	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,475,377	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	100,153	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	134,227	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	606,140	0	0	0	90.00
91.00	09100 EMERGENCY	0	5,023,252	0	0	0	91.00
91.01	09101 PARTIAL HOSPITALIZATION	0	158,548	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,684,687	0	0	0	92.00
200.00	Total (lines 50-199)	0	74,636,194	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
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Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0			55.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MRI	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0			62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0			76.00
76.97	07697 CARDIAC REHABILITATION	0	0			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0			76.98
76.99	07699 LI THOTRI PSY	0	0			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0			90.00
91.00	09100 EMERGENCY	0	0			91.00
91.01	09101 PARTIAL HOSPITALIZATION	0	0			91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.182903	13,752,069	0	0	2,515,295	50.00
51.00	05100	RECOVERY ROOM	0.095187	1,439,655	0	0	137,036	51.00
53.00	05300	ANESTHESIOLOGY	0.026305	3,337,569	0	0	87,795	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168879	7,242,687	0	0	1,223,138	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.243064	3,295,327	0	0	800,975	55.00
57.00	05700	CT SCAN	0.035886	4,850,759	0	0	174,074	57.00
58.00	05800	MRI	0.044165	2,689,245	0	0	118,771	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.146712	4,049,709	0	0	594,141	59.00
60.00	06000	LABORATORY	0.131046	6,774,224	1,834	0	887,735	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.183993	213,048	0	0	39,199	63.00
65.00	06500	RESPIRATORY THERAPY	0.181102	228,081	0	0	41,306	65.00
66.00	06600	PHYSICAL THERAPY	0.334873	539,852	0	0	180,782	66.00
69.00	06900	ELECTROCARDIOLOGY	0.044685	3,608,879	0	0	161,263	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.053822	321,790	0	0	17,319	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893	4,297,584	17,077	0	910,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.325643	2,813,332	34,580	0	916,142	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113192	6,475,377	0	0	732,961	73.00
74.00	07400	RENAL DIALYSIS	0.268750	100,153	0	0	26,916	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.424248	134,227	0	0	56,946	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.217310	606,140	0	0	131,720	90.00
91.00	09100	EMERGENCY	0.100504	5,023,252	0	0	504,857	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.315900	158,548	0	0	50,085	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.223987	2,684,687	0	0	601,335	92.00
200.00		Subtotal (see instructions)		74,636,194	53,491	0	10,910,419	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		74,636,194	53,491	0	10,910,419	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 11:57 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	240	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,618	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11,261	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 PARTIAL HOSPITALIZATION	0	0		91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	15,119	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	15,119	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140224 Component CCN: 14S224		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVIII		Subprovider - IPF		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	1,563,958	98,941,456	0.015807	0	0 50.00
51.00	05100	RECOVERY ROOM	95,157	14,213,548	0.006695	0	0 51.00
53.00	05300	ANESTHESIOLOGY	46,086	24,348,940	0.001893	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	760,431	40,999,429	0.018547	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	224,942	10,542,993	0.021336	0	0 55.00
57.00	05700	CT SCAN	71,870	25,660,403	0.002801	0	0 57.00
58.00	05800	MRI	44,675	15,977,713	0.002796	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	347,161	19,266,108	0.018019	0	0 59.00
60.00	06000	LABORATORY	576,797	81,687,107	0.007061	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,167	4,388,115	0.004596	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	141,125	11,483,680	0.012289	0	0 65.00
66.00	06600	PHYSICAL THERAPY	325,365	17,631,408	0.018454	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	26,971	20,166,901	0.001337	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,699	1,710,550	0.002162	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	246,781	46,998,487	0.005251	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	171,816	21,688,629	0.007922	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	453,815	119,912,994	0.003785	0	0 73.00
74.00	07400	RENAL DIALYSIS	14,007	2,126,772	0.006586	0	0 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	2,899	266,389	0.010883	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LI THOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	32,036	3,036,335	0.010551	0	0 90.00
91.00	09100	EMERGENCY	98,060	35,775,015	0.002741	0	0 91.00
91.01	09101	PARTIAL HOSPITALIZATION	8,263	1,074,086	0.007693	0	0 91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,767,061	0.000000	0	0 92.00
200.00		Total (lines 50-199)	5,276,081	626,664,119		0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224 Component CCN: 14S224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
	Title XVIII	Subprovider - IPF	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
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
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
91.01	09101 PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
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: 140224 Component CCN: 14S224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
Title XVIII		Subprovider - IPF	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	98,941,456	0.000000	0.000000		0 50.00
51.00	05100 RECOVERY ROOM	0	14,213,548	0.000000	0.000000		0 51.00
53.00	05300 ANESTHESIOLOGY	0	24,348,940	0.000000	0.000000		0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	40,999,429	0.000000	0.000000		0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	10,542,993	0.000000	0.000000		0 55.00
57.00	05700 CT SCAN	0	25,660,403	0.000000	0.000000		0 57.00
58.00	05800 MRI	0	15,977,713	0.000000	0.000000		0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0	19,266,108	0.000000	0.000000		0 59.00
60.00	06000 LABORATORY	0	81,687,107	0.000000	0.000000		0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000		0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	4,388,115	0.000000	0.000000		0 63.00
65.00	06500 RESPIRATORY THERAPY	0	11,483,680	0.000000	0.000000		0 65.00
66.00	06600 PHYSICAL THERAPY	0	17,631,408	0.000000	0.000000		0 66.00
69.00	06900 ELECTROCARDIOLOGY	0	20,166,901	0.000000	0.000000		0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,710,550	0.000000	0.000000		0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,998,487	0.000000	0.000000		0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	21,688,629	0.000000	0.000000		0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	119,912,994	0.000000	0.000000		0 73.00
74.00	07400 RENAL DIALYSIS	0	2,126,772	0.000000	0.000000		0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000		0 76.00
76.97	07697 CARDIAC REHABILITATION	0	266,389	0.000000	0.000000		0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000		0 76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0.000000		0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	3,036,335	0.000000	0.000000		0 90.00
91.00	09100 EMERGENCY	0	35,775,015	0.000000	0.000000		0 91.00
91.01	09101 PARTIAL HOSPITALIZATION	0	1,074,086	0.000000	0.000000		0 91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8,767,061	0.000000	0.000000		0 92.00
200.00	Total (lines 50-199)	0	626,664,119				0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224 Component CCN: 14S224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
Title XVIII		Subprovider - IPF	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIAC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
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: 140224 Component CCN: 14S224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
Title XVII		Subprovider - IPF	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 PARTIAL HOSPITALIZATION	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140224 Component CCN: 14T224		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/26/2015 11:57 am	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,563,958	98,941,456	0.015807	25,521	403 50.00
51.00	05100	RECOVERY ROOM	95,157	14,213,548	0.006695	3,752	25 51.00
53.00	05300	ANESTHESIOLOGY	46,086	24,348,940	0.001893	4,484	8 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	760,431	40,999,429	0.018547	72,644	1,347 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	224,942	10,542,993	0.021336	0	0 55.00
57.00	05700	CT SCAN	71,870	25,660,403	0.002801	66,295	186 57.00
58.00	05800	MRI	44,675	15,977,713	0.002796	17,932	50 58.00
59.00	05900	CARDIAC CATHETERIZATION	347,161	19,266,108	0.018019	0	0 59.00
60.00	06000	LABORATORY	576,797	81,687,107	0.007061	507,668	3,585 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,167	4,388,115	0.004596	13,139	60 63.00
65.00	06500	RESPIRATORY THERAPY	141,125	11,483,680	0.012289	205,687	2,528 65.00
66.00	06600	PHYSICAL THERAPY	325,365	17,631,408	0.018454	1,916,863	35,374 66.00
69.00	06900	ELECTROCARDIOLOGY	26,971	20,166,901	0.001337	45,582	61 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,699	1,710,550	0.002162	7,199	16 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	246,781	46,998,487	0.005251	259,871	1,365 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	171,816	21,688,629	0.007922	8,080	64 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	453,815	119,912,994	0.003785	1,069,987	4,050 73.00
74.00	07400	RENAL DIALYSIS	14,007	2,126,772	0.006586	158,505	1,044 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	2,899	266,389	0.010883	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	32,036	3,036,335	0.010551	0	0 90.00
91.00	09100	EMERGENCY	98,060	35,775,015	0.002741	0	0 91.00
91.01	09101	PARTIAL HOSPITALIZATION	8,263	1,074,086	0.007693	0	0 91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,767,061	0.000000	0	0 92.00
200.00		Total (lines 50-199)	5,276,081	626,664,119		4,383,209	50,166 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224 Component CCN: 14T224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
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
91.01	09101 PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
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: 140224 Component CCN: 14T224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	98,941,456	0.000000	0.000000	25,521	50.00
51.00	05100 RECOVERY ROOM	0	14,213,548	0.000000	0.000000	3,752	51.00
53.00	05300 ANESTHESIOLOGY	0	24,348,940	0.000000	0.000000	4,484	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	40,999,429	0.000000	0.000000	72,644	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	10,542,993	0.000000	0.000000	0	55.00
57.00	05700 CT SCAN	0	25,660,403	0.000000	0.000000	66,295	57.00
58.00	05800 MRI	0	15,977,713	0.000000	0.000000	17,932	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	19,266,108	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	81,687,107	0.000000	0.000000	507,668	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	4,388,115	0.000000	0.000000	13,139	63.00
65.00	06500 RESPIRATORY THERAPY	0	11,483,680	0.000000	0.000000	205,687	65.00
66.00	06600 PHYSICAL THERAPY	0	17,631,408	0.000000	0.000000	1,916,863	66.00
69.00	06900 ELECTROCARDIOLOGY	0	20,166,901	0.000000	0.000000	45,582	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,710,550	0.000000	0.000000	7,199	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,998,487	0.000000	0.000000	259,871	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	21,688,629	0.000000	0.000000	8,080	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	119,912,994	0.000000	0.000000	1,069,987	73.00
74.00	07400 RENAL DIALYSIS	0	2,126,772	0.000000	0.000000	158,505	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	266,389	0.000000	0.000000	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	3,036,335	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	35,775,015	0.000000	0.000000	0	91.00
91.01	09101 PARTIAL HOSPITALIZATION	0	1,074,086	0.000000	0.000000	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8,767,061	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	626,664,119			4,383,209	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224 Component CCN: 14T224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	322	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	341	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3,231	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
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
91.01 09101 PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	3,894	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224 Component CCN: 14T224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
Title XVII		Subprovider - IRF	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 PARTIAL HOSPITALIZATION	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224 Component CCN: 14T224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 11:57 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.182903	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.095187	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0.026305	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168879	322	0	0	54	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.243064	0	0	0	0	55.00
57.00 05700 CT SCAN	0.035886	0	0	0	0	57.00
58.00 05800 MRI	0.044165	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.146712	0	0	0	0	59.00
60.00 06000 LABORATORY	0.131046	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.183993	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.181102	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.334873	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.044685	341	0	0	15	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.053822	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.325643	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.113192	3,231	0	0	366	73.00
74.00 07400 RENAL DIALYSIS	0.268750	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.424248	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.217310	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.100504	0	0	0	0	91.00
91.01 09101 PARTIAL HOSPITALIZATION	0.315900	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.223987	0	0	0	0	92.00
200.00 Subtotal (see instructions)		3,894	0	0	435	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		3,894	0	0	435	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 11:57 am
	Component CCN: 14T224	Title XVII I	Subprovider - IRF

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 PARTIAL HOSPITALIZATION	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	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	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224 Component CCN: 145568	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
	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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
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
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
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: 140224 Component CCN: 145568	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Total	Total	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	Charges (from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	98,941,456	0.000000	0.000000	7,101	50.00
51.00 05100 RECOVERY ROOM	0	14,213,548	0.000000	0.000000	0	51.00
53.00 05300 ANESTHESIOLOGY	0	24,348,940	0.000000	0.000000	3,350	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	40,999,429	0.000000	0.000000	168,754	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	10,542,993	0.000000	0.000000	5,492	55.00
57.00 05700 CT SCAN	0	25,660,403	0.000000	0.000000	0	57.00
58.00 05800 MRI	0	15,977,713	0.000000	0.000000	14,935	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	19,266,108	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	81,687,107	0.000000	0.000000	1,215,981	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	4,388,115	0.000000	0.000000	10,680	63.00
65.00 06500 RESPIRATORY THERAPY	0	11,483,680	0.000000	0.000000	467,333	65.00
66.00 06600 PHYSICAL THERAPY	0	17,631,408	0.000000	0.000000	2,621,093	66.00
69.00 06900 ELECTROCARDIOLOGY	0	20,166,901	0.000000	0.000000	45,139	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	1,710,550	0.000000	0.000000	5,008	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,998,487	0.000000	0.000000	1,046,667	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	21,688,629	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	119,912,994	0.000000	0.000000	3,576,535	73.00
74.00 07400 RENAL DIALYSIS	0	2,126,772	0.000000	0.000000	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	266,389	0.000000	0.000000	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	3,036,335	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	35,775,015	0.000000	0.000000	0	91.00
91.01 09101 PARTIAL HOSPITALIZATION	0	1,074,086	0.000000	0.000000	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8,767,061	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	626,664,119			9,188,068	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140224 Component CCN: 145568		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am	
		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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIAC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 11:57 am
	Component CCN: 145568	Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
	23.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 PARTIAL HOSPITALIZATION	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224 Component CCN: 145568	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 11:57 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.182903	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.095187	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0.026305	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168879	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.243064	0	0	0	0	55.00
57.00 05700 CT SCAN	0.035886	0	0	0	0	57.00
58.00 05800 MRI	0.044165	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.146712	0	0	0	0	59.00
60.00 06000 LABORATORY	0.131046	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.183993	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.181102	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.334873	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.044685	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.053822	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.325643	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.113192	0	0	3,423	0	73.00
74.00 07400 RENAL DIALYSIS	0.268750	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.424248	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.217310	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.100504	0	0	0	0	91.00
91.01 09101 PARTIAL HOSPITALIZATION	0.315900	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.223987	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	3,423	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	3,423	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 11:57 am
	Component CCN: 145568	Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	387		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 PARTIAL HOSPITALIZATION	0	0		91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	387		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	387		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/26/2015 11:57 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		43,110	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		43,110	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)		41,067	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		18,148	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)		41,436,854	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)		41,436,854	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)		41,436,854	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)		961.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,443,676	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)		17,443,676	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	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	6,209,869	3,177	1,954.63	1,835	3,586,746	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)					18,950,891	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					39,981,313	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)					2,096,026	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					998,418	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,094,444	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					36,886,869	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)					2,043	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					961.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,963,711	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,202,914	41,436,854	0.101429	1,963,711	199,177	90.00
91.00	Nursing School cost	0	41,436,854	0.000000	1,963,711	0	91.00
92.00	Allied health cost	0	41,436,854	0.000000	1,963,711	0	92.00
93.00	All other Medical Education	0	41,436,854	0.000000	1,963,711	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224 Component CCN: 14S224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Subprovider - IPF	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)		8,826	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,826	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)		8,826	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,694,854	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,694,854	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		7,694,854	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)		871.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 14S224				Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVIII		Subprovider - IPF		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	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00	0	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	0	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	0	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	0	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224 Component CCN: 14S224		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVIII		Subprovider - IPF		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	672,851	7,694,854	0.087442	0	0	90.00
91.00	Nursing School cost	0	7,694,854	0.000000	0	0	91.00
92.00	Allied health cost	0	7,694,854	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,694,854	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 14T224		Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,477	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,477	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)		2,477	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,597	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)		2,432,991	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)		2,432,991	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)		2,432,991	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)		982.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,568,621	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,568,621	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 14T224				Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							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)					992,515		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,561,136		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)					162,479		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					50,166		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					212,645		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,348,491		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224 Component CCN: 14T224		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	252,019	2,432,991	0.103584	0	0	90.00
91.00	Nursing School cost	0	2,432,991	0.000000	0	0	91.00
92.00	Allied health cost	0	2,432,991	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,432,991	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224 Component CCN: 145568	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am
		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)		6,060	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,060	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)		6,060	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)		4,506	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)		4,655,642	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)		4,655,642	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)		4,655,642	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: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1	
		Component CCN: 145568		Date/Time Prepared: 5/26/2015 11:57 am	
		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)				4,655,642 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				768.26 71.00
72.00	Program routine service cost (line 9 x line 71)				3,461,780 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)				3,461,780 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)				3,461,780 83.00
84.00	Program inpatient ancillary services (see instructions)				1,784,466 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)				5,246,246 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: 140224 Component CCN: 145568		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am	
		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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/26/2015 11:57 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		43,110	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		43,110	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)		41,067	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,459	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		4,863	15.00
16.00	Nursery days (title V or XIX only)		2,506	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)		41,203,245	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)		41,203,245	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)		41,203,245	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)		955.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,394,468	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,394,468	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am		
Cost Center Description			Title XIX		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	3,943,822	4,863	810.99	2,506	2,032,341	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,209,869	3,177	1,954.63	157	306,877	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)					3,154,805	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,888,491	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,043	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					955.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,952,638	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,202,914	41,203,245	0.102004	1,952,638	199,177	90.00
91.00	Nursing School cost	0	41,203,245	0.000000	1,952,638	0	91.00
92.00	Allied health cost	0	41,203,245	0.000000	1,952,638	0	92.00
93.00	All other Medical Education	0	41,203,245	0.000000	1,952,638	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 14T224		Date/Time Prepared: 5/26/2015 11:57 am
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,477	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,477	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)		2,477	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)		223	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		4,863	15.00
16.00	Nursery days (title V or XIX only)		2,506	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)		2,432,991	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)		2,432,991	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)		2,432,991	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)		982.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		219,037	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)		219,037	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 14T224				Date/Time Prepared: 5/26/2015 11:57 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							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)					78,268		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					297,305		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224 Component CCN: 14T224		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 11:57 am	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	252,019	2,432,991	0.103584	0	0	90.00
91.00	Nursing School cost	0	2,432,991	0.000000	0	0	91.00
92.00	Allied health cost	0	2,432,991	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,432,991	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 11:57 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		40,037,822	30.00
31.00	03100	INTENSIVE CARE UNIT		7,046,976	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.182903	11,901,926	50.00
51.00	05100	RECOVERY ROOM	0.095187	1,708,818	51.00
53.00	05300	ANESTHESIOLOGY	0.026305	2,771,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168879	6,463,731	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.243064	259,513	55.00
57.00	05700	CT SCAN	0.035886	4,475,698	57.00
58.00	05800	MRI	0.044165	1,964,027	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.146712	5,396,398	59.00
60.00	06000	LABORATORY	0.131046	22,449,872	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.183993	2,018,705	63.00
65.00	06500	RESPIRATORY THERAPY	0.181102	5,478,119	65.00
66.00	06600	PHYSICAL THERAPY	0.334873	2,064,914	66.00
69.00	06900	ELECTROCARDIOLOGY	0.044685	4,939,622	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.053822	211,389	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893	12,140,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.325643	5,167,948	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113192	31,930,877	73.00
74.00	07400	RENAL DIALYSIS	0.268750	1,369,205	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.424248	6,506	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.217310	118,629	90.00
91.00	09100	EMERGENCY	0.100504	6,629,577	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.315900	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.223987	817,154	92.00
200.00		Total (sum of lines 50-94 and 96-98)		130,284,543	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)		130,284,543	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140224 Component CCN: 14T224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVIIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		3,040,692		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.182903	25,521	4,668	50.00
51.00	05100 RECOVERY ROOM	0.095187	3,752	357	51.00
53.00	05300 ANESTHESIOLOGY	0.026305	4,484	118	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168879	72,644	12,268	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.243064	0	0	55.00
57.00	05700 CT SCAN	0.035886	66,295	2,379	57.00
58.00	05800 MRI	0.044165	17,932	792	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.146712	0	0	59.00
60.00	06000 LABORATORY	0.131046	507,668	66,528	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.183993	13,139	2,417	63.00
65.00	06500 RESPIRATORY THERAPY	0.181102	205,687	37,250	65.00
66.00	06600 PHYSICAL THERAPY	0.334873	1,916,863	641,906	66.00
69.00	06900 ELECTROCARDIOLOGY	0.044685	45,582	2,037	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.053822	7,199	387	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893	259,871	55,065	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.325643	8,080	2,631	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113192	1,069,987	121,114	73.00
74.00	07400 RENAL DIALYSIS	0.268750	158,505	42,598	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.424248	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.217310	0	0	90.00
91.00	09100 EMERGENCY	0.100504	0	0	91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.315900	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.223987	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,383,209	992,515	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,383,209		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140224 Component CCN: 145568	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 11:57 am
		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
40.00	04000 SUBPROVIDER - I PF		0	40.00
41.00	04100 SUBPROVIDER - I RF		0	41.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.182903	7,101	1,299 50.00
51.00	05100 RECOVERY ROOM	0.095187	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.026305	3,350	88 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168879	168,754	28,499 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.243064	5,492	1,335 55.00
57.00	05700 CT SCAN	0.035886	0	0 57.00
58.00	05800 MRI	0.044165	14,935	660 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.146712	0	0 59.00
60.00	06000 LABORATORY	0.131046	1,215,981	159,349 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.183993	10,680	1,965 63.00
65.00	06500 RESPIRATORY THERAPY	0.181102	467,333	84,635 65.00
66.00	06600 PHYSICAL THERAPY	0.334873	2,621,093	877,733 66.00
69.00	06900 ELECTROCARDIOLOGY	0.044685	45,139	2,017 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.053822	5,008	270 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893	1,046,667	221,781 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.325643	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113192	3,576,535	404,835 73.00
74.00	07400 RENAL DIALYSIS	0.268750	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0.424248	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.217310	0	0 90.00
91.00	09100 EMERGENCY	0.100504	0	0 91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.315900	0	0 91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.223987	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		9,188,068	1,784,466 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		9,188,068	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 11:57 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		10,085,605	30.00
31.00	03100	INTENSIVE CARE UNIT		839,560	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		2,736,684	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.182903	1,624,578	297,140 50.00
51.00	05100	RECOVERY ROOM	0.095187	2,790,621	265,631 51.00
53.00	05300	ANESTHESIOLOGY	0.026305	2,387,826	62,812 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168879	737,637	124,571 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.243064	71,559	17,393 55.00
57.00	05700	CT SCAN	0.035886	678,638	24,354 57.00
58.00	05800	MRI	0.044165	222,815	9,841 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.146712	800,705	117,473 59.00
60.00	06000	LABORATORY	0.131046	4,449,476	583,086 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.183993	147,089	27,063 63.00
65.00	06500	RESPIRATORY THERAPY	0.181102	827,190	149,806 65.00
66.00	06600	PHYSICAL THERAPY	0.334873	230,918	77,328 66.00
69.00	06900	ELECTROCARDIOLOGY	0.044685	624,868	27,922 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.053822	46,524	2,504 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893	2,677,362	567,314 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.325643	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.113192	6,528,477	738,971 73.00
74.00	07400	RENAL DIALYSIS	0.268750	97,745	26,269 74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.424248	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.217310	1,430	311 90.00
91.00	09100	EMERGENCY	0.100504	286,400	28,784 91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.315900	0	0 91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.223987	27,824	6,232 92.00
200.00		Total (sum of lines 50-94 and 96-98)		25,259,682	3,154,805 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		25,259,682	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140224 Component CCN: 14S224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 11:57 am	
		Title XIX	Subprovider - IPF	Cost	
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		3,370,111		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.182903	2,809	514	50.00
51.00	05100 RECOVERY ROOM	0.095187	20,033	1,907	51.00
53.00	05300 ANESTHESIOLOGY	0.026305	21,434	564	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168879	19,486	3,291	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.243064	0	0	55.00
57.00	05700 CT SCAN	0.035886	21,103	757	57.00
58.00	05800 MRI	0.044165	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.146712	0	0	59.00
60.00	06000 LABORATORY	0.131046	542,121	71,043	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.183993	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.181102	12,953	2,346	65.00
66.00	06600 PHYSICAL THERAPY	0.334873	7,662	2,566	66.00
69.00	06900 ELECTROCARDIOLOGY	0.044685	23,728	1,060	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.053822	1,891	102	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893	1,063	225	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.325643	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113192	711,603	80,548	73.00
74.00	07400 RENAL DIALYSIS	0.268750	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.424248	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.217310	0	0	90.00
91.00	09100 EMERGENCY	0.100504	35,560	3,574	91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.315900	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.223987	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,421,446	168,497	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,421,446		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140224 Component CCN: 14T224	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 11:57 am	
		Title XIX	Subprovider - IRF	Cost	
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
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		250,607		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.182903	1,771	324	50.00
51.00	05100 RECOVERY ROOM	0.095187	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.026305	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168879	6,028	1,018	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.243064	0	0	55.00
57.00	05700 CT SCAN	0.035886	4,786	172	57.00
58.00	05800 MRI	0.044165	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.146712	0	0	59.00
60.00	06000 LABORATORY	0.131046	44,428	5,822	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.183993	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.181102	10,748	1,946	65.00
66.00	06600 PHYSICAL THERAPY	0.334873	149,047	49,912	66.00
69.00	06900 ELECTROCARDIOLOGY	0.044685	1,059	47	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.053822	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.211893	11,384	2,412	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.325643	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.113192	117,370	13,285	73.00
74.00	07400 RENAL DIALYSIS	0.268750	12,390	3,330	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.424248	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.217310	0	0	90.00
91.00	09100 EMERGENCY	0.100504	0	0	91.00
91.01	09101 PARTIAL HOSPITALIZATION	0.315900	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.223987	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		359,011	78,268	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)		359,011		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		21,085,195	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,085,267	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		731,424	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		3,822,902	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		229.65	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)		139.15	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)		22.76	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.		0.64	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		-0.89	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.		3.50	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)		3.50	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)		121.86	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		107.75	10.00
11.00	FTE count for residents in dental and podiatric programs.		12.21	11.00
12.00	Current year allowable FTE (see instructions)		119.96	12.00
13.00	Total allowable FTE count for the prior year.		120.57	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.		123.74	14.00
15.00	Sum of lines 12 through 14 divided by 3.		121.42	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		121.42	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.528718	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.483472	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.483472	21.00
22.00	IME payment adjustment (see instructions)		7,480,208	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (F)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-14.11	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		7,480,208	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.43	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.78	31.00
32.00	Sum of lines 30 and 31		32.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.80	33.00
34.00	Disproportionate share adjustment (see instructions)		901,455	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000325790	0.000350230	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,947,220	2,678,433	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,204,358	675,112	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,879,470		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		40,163,019		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		40,163,019		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,187,197		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		5,507,152		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 (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		48,857,368		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		48,857,368		61.00
62.00	Deductibles billed to program beneficiaries		2,789,728		62.00
63.00	Coinurance billed to program beneficiaries		115,960		63.00
64.00	Allowable bad debts (see instructions)		784,329		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		509,814		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		684,467		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		46,461,494		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		80,434		70.93
70.94	HRR adjustment amount (see instructions)		-115,200		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		46,426,728		71.00
71.01	Sequestration adjustment (see instructions)		928,535		71.01
72.00	Interim payments		44,150,462		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		1,347,731		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		44,368		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 5/26/2015 11:57 am	
		PPS					
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	8.43	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	23.78	0.00			23.78	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	32.21	0.00			23.78	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	229.65	0.00			229.65	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	12.80	0.00			8.83	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	8.43	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	5.43	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	6,934	0			6,934	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	3,299	0			3,299	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	431	0			431	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	1,016	0			1,016	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	11,680	0			11,680	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	49,107	0			49,107	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	49,107	0			49,107	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	23.78	0.00			23.78	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140224		Period: From 01/01/2014 To 12/31/2014		Worksheet DSH Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVII I		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	15.79		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		15.79		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		15.79		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet DSH Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Hospital	PPS

		Revised Percentage	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE		6.00	
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	8.83	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	8.83	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	8.83	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		15,119	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,910,419	2.00
3.00	PPS payments		10,910,719	3.00
4.00	Outlier payment (see instructions)		100,945	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		15,119	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		53,491	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		53,491	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		53,491	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		38,372	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)		15,119	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)		11,011,664	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		10,331	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,405,389	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		8,611,063	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		1,254,122	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		9,865,185	30.00
31.00	Primary payer payments		1,787	31.00
32.00	Subtotal (line 30 minus line 31)		9,863,398	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		470,639	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		305,915	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		391,608	36.00
37.00	Subtotal (see instructions)		10,169,313	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,169,313	40.00
40.01	Sequestration adjustment (see instructions)		203,386	40.01
41.00	Interim payments		10,207,796	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-241,869	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
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/26/2015 11:57 am
		Component CCN: 14T224	Title XVII I	Subprovider - IRF
				PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		435	2.00
3.00	PPS payments		930	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		930	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)		247	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		683	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		683	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		683	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		683	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		683	40.00
40.01	Sequestration adjustment (see instructions)		14	40.01
41.00	Interim payments		113	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		556	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
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224 Component CCN: 145568	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		387	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 Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		387	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,423	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		3,423	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		3,423	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,036	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)		387	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 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		387	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		387	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		387	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		387	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		387	40.00
40.01	Sequestration adjustment (see instructions)		8	40.01
41.00	Interim payments		872	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-493	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
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140224

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2015 11:57 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		38,628,134		8,434,342	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		5,885,342		1,505,499	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/15/2014	52,124	08/15/2014	395,000	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		12/11/2014	415,138	12/11/2014	127,045	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)		-363,014		267,955	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)		44,150,462		10,207,796	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,347,731		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		241,869	6.02
7.00	Total Medicare program liability (see instructions)		45,498,193		9,965,927	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: 140224
Component CCN: 14T224

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2015 11:57 am
PPS

Title XVIII

Subprovider -
IRF

		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					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		2,479,165		113	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)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/25/2013	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		08/15/2014	33,096		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)		-33,096		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)		2,446,069		113	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		45,433		556	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,491,502		669	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: 140224
Component CCN: 145568

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2015 11:57 am
PPS

Title XVIII

Skilled Nursing Facility

		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					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		1,853,718		872	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)		1,853,718		872	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		540		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		493	6.02
7.00	Total Medicare program liability (see instructions)		1,854,258		379	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: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			9,321 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			19,983 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2,683 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			44,244 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			782,508,898 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6,672,154 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,408,421 8.00
9.00	Sequestration adjustment amount (see instructions)			28,168 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,380,253 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,117,308 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)			262,945 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224 Component CCN: 14S224	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/26/2015 11:57 am
		Title XVII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			0 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			24.180822 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			0 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			0 18.00
19.00	Deductibles			0 19.00
20.00	Subtotal (line 18 minus line 19)			0 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			0 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			0 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			0 31.00
31.01	Sequestration adjustment (see instructions)			0 31.01
32.00	Interim payments			0 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224 Component CCN: 14T224	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/26/2015 11:57 am
		Title VIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,419,217 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0543 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			105,962 3.00
4.00	Outlier Payments			55,161 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			6.786301 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,580,340 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,580,340 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,580,340 19.00
20.00	Deductibles			14,592 20.00
21.00	Subtotal (line 19 minus line 20)			2,565,748 21.00
22.00	Coinsurance			23,840 22.00
23.00	Subtotal (line 21 minus line 22)			2,541,908 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			679 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			441 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,542,349 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,542,349 32.00
32.01	Sequestration adjustment (see instructions)			50,847 32.01
33.00	Interim payments			2,446,069 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34			45,433 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			58,416 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			55,161 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224 Component CCN: 145568	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VI Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,968,280	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)		1,968,280	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		76,732	7.00
8.00	Allowable bad debts (see instructions)		849	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		552	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,892,100	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		1,892,100	15.00
15.01	Sequestration adjustment (see instructions)		37,842	15.01
16.00	Interim payments		1,853,718	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		540	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2015 11:57 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		6,888,491		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		6,888,491	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		6,888,491	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		25,259,682	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		25,259,682	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		25,259,682	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		18,371,191	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		6,888,491	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		6,888,491	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6,888,491	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		6,888,491	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		6,888,491	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		6,888,491	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		6,888,491	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224 Component CCN: 14T224	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2015 11:57 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	297,305		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	297,305	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	297,305	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	359,011	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	359,011	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	359,011	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	61,706	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	297,305	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	297,305	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	297,305	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	297,305	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	297,305	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	297,305	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	297,305	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
OVERRIDES				
109.00	Override Ancillary service charges (line 9)	0	0	109.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/26/2015 11:57 am	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			142.44	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			23.61	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.79	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-3.75	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			7.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			120.29	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			107.81	6.00
7.00	Enter the lesser of line 5 or line 6			107.81	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	93.33	13.41	106.74	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	93.33	13.41	106.74	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		12.21		10.00
11.00	Total weighted FTE count	93.33	25.62		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	93.91	24.58		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	97.10	18.14		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	94.78	22.78		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	94.78	22.78		17.00
18.00	Per resident amount	134,702.00	129,838.00		18.00
19.00	Approved amount for resident costs	12,767,056	2,957,710	15,724,766	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			15,724,766	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	21,580	2,683		26.00
27.00	Total Inpatient Days (see instructions)	55,547	55,547		27.00
28.00	Ratio of inpatient days to total inpatient days	0.388500	0.048301		28.00
29.00	Program direct GME amount	6,109,072	759,522		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		107,320		30.00
31.00	Net Program direct GME amount			6,761,274	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		2,126,772	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		47,972,509	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		47,972,509	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		10,926,360	42.00
43.00	Primary payer payments (see instructions)		1,787	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		10,924,573	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		58,897,082	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.814514	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.185486	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		6,761,274	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		5,507,152	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		1,254,122	50.00

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

Provider CCN: 140224

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

Worksheet G

Date/Time Prepared:
5/26/2015 11:57 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	27,877	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	40,333,685	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,097,224	0	0	0	6.00
7.00	Inventory	4,193,043	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	246,795	0	0	0	9.00
10.00	Due from other funds	10,049,464	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	40,753,640	0	0	0	11.00
FIXED ASSETS						
12.00	Land	7,327,666	0	0	0	12.00
13.00	Land improvements	11,980,239	0	0	0	13.00
14.00	Accumulated depreciation	-6,443,049	0	0	0	14.00
15.00	Buildings	65,594,666	0	0	0	15.00
16.00	Accumulated depreciation	-35,277,230	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	58,396,932	0	0	0	23.00
24.00	Accumulated depreciation	-31,406,242	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)	70,172,982	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,174,700	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,174,700	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	114,101,322	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,745,138	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-5,197,345	0	0	0	43.00
44.00	Other current liabilities	32,875,196	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,422,989	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	21,188,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	21,188,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	50,610,989	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	63,490,333				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)	63,490,333	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	114,101,322	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140224

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

Worksheet G-1

Date/Time Prepared:
5/26/2015 11:57 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		59,098,618		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,086,565			2.00
3.00	Total (sum of line 1 and line 2)		63,185,183		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00	TRANSFER FROM AFFILIATE	305,149		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		305,149		0	10.00
11.00	Subtotal (line 3 plus line 10)		63,490,332		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		63,490,332		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00	TRANSFER FROM AFFILIATE		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: 140224

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2015 11:57 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	139,991,325		139,991,325	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	4,445,736		4,445,736	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	5,495,583		5,495,583	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)	149,932,644		149,932,644	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	12,522,455		12,522,455	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)	12,522,455		12,522,455	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	162,455,099		162,455,099	17.00
18.00	Ancillary services	315,123,404	295,477,533	610,600,937	18.00
19.00	Outpatient services	0	26,680,400	26,680,400	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	477,578,503	322,157,933	799,736,436	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		195,605,326		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	RECONCILING ITEM	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)		195,605,326		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140224

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

Worksheet G-3

Date/Time Prepared:
5/26/2015 11:57 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	799,736,436	1.00
2.00	Less contractual allowances and discounts on patients' accounts	605,312,396	2.00
3.00	Net patient revenues (line 1 minus line 2)	194,424,040	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	195,605,326	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,181,286	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	9,904	6.00
7.00	Income from investments	-368,052	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	REVENUE FROM OTHER SOURCES	5,538,651	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	87,348	24.01
25.00	Total other income (sum of lines 6-24)	5,267,851	25.00
26.00	Total (line 5 plus line 25)	4,086,565	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)	4,086,565	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet I-5 Date/Time Prepared: 5/26/2015 11:57 am
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		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)			2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)			3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/26/2015 11:57 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,251,438	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		48,467	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)		121.22	3.00
4.00	Number of interns & residents (see instructions)		121.42	4.00
5.00	Indirect medical education percentage (see instructions)		32.67	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		735,545	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		8.43	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		23.78	8.00
9.00	Sum of lines 7 and 8		32.21	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.74	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		151,747	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		3,187,197	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

ALL INCLUSIVE RATE DATA - METHOD E		Provider CCN: 140224	Period: From 01/01/2014 To 12/31/2014	Worksheet AIR Not a CMS Worksheet Date/Time Prepared: 5/26/2015 11:57 am
			1.00	
1.00	Total general inpatient routine service cost.		41,436,854	1.00
2.00	Total inpatient days.		49,107	2.00
3.00	Cost per day.		843.81	3.00
4.00	Percentage (93% = Short Term; 98% = Long Term).		0	4.00
5.00	Reduced cost per day.		0.00	5.00
6.00	Ancillary percentage.		0	6.00
7.00	Ancillary cost per day.		0.00	7.00
8.00	Inpatient Part B days.		0	8.00
9.00	Total Part B ancillary cost.		0	9.00