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: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/20/2015 6:17 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/20/2015 Time: 6:17 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE OUR LADY OFTHE RESURRECTION (140251) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	691,473	65,386	-156,040	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-37		0	7.00
200.00	Total	0	691,473	65,349	-156,040	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/20/2015 6:15 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5645 WEST ADDISON STREET	PO Box:			1.00
2.00	City: CHICAGO	State: IL	Zip Code: 60634	County: COOK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PRESENCE OUR LADY OFTHE RESURRECTION	140251	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	OLRMC SKILLED NURSING FACILITY	145548	16974		07/01/1985	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.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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.	4,247	3,678	0	0	197	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/20/2015 6:15 pm

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/20/2015 6:15 pm

		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)	2.12	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/20/2015 6:15 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/20/2015 6:15 pm

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/20/2015 6:15 pm

		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		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 SOUTH WACKER	PO Box:		142.00
143.00	City: CHICAGO	State:	Zip Code: 60606	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y	145.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/20/2015 6:15 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	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: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/20/2015 6:15 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/17/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/20/2015 6:15 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SANDI	COSLER			41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815/806-2327	SANDRA.COSLER@PRESENCEHEALTH.ORG			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/20/2015 6:15 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/20/2015 6:15 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	193	70,445	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)		193	70,445	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	20	7,300	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		213	77,745	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	66	24,090		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)		279				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/20/2015 6:15 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	13,178	3,819	26,334			1.00
2.00	HMO and other (see instructions)	3,273	3,321				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)	13,178	3,819	26,334			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	3,034	982	6,222			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	16,212	4,801	32,556	2.57	644.31	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	10,653	0	12,886	0.00	51.65	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)				2.57	695.96	27.00
28.00	Observation Bed Days		96	3,250			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/20/2015 6:15 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,010	1,223	6,604	1.00
2.00	HMO and other (see instructions)			585	846		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	3,010	1,223	6,604	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/20/2015 6:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	43,105,256	45,341	43,150,597	1,447,603.00	29.81	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	38,740	38,740	1,211.00	31.99	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	2,864,163	0	2,864,163	107,425.00	26.66	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,630,131	0	3,630,131	94,025.00	38.61	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		7,931,362	0	7,931,362	157,857.00	50.24	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)		10,353,986	0	10,353,986			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		737,656	0	737,656			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		9,977	0	9,977			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	13,620	0	13,620	118.00	115.42	26.00
27.00	Administrative & General	5.00	2,489,007	138,586	2,627,593	90,850.00	28.92	27.00
28.00	Administrative & General under contract (see inst.)		93,245	0	93,245	769.00	121.25	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,435,568	0	1,435,568	63,301.00	22.68	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	980,568	0	980,568	76,990.00	12.74	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,175,203	-409,471	765,732	51,419.00	14.89	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	409,471	409,471	27,496.00	14.89	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	941,222	0	941,222	22,309.00	42.19	38.00
39.00	Central Services and Supply	14.00	316,482	0	316,482	14,987.00	21.12	39.00
40.00	Pharmacy	15.00	1,777,380	0	1,777,380	43,906.00	40.48	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/20/2015 6:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	1,964,587	-93,245	1,871,342	65,826.00	28.43	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/20/2015 6:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		43,198,501	6,601	43,205,102	1,447,161.00	29.86	1.00
2.00	Excluded area salaries (see instructions)		2,864,163	0	2,864,163	107,425.00	26.66	2.00
3.00	Subtotal salaries (line 1 minus line 2)		40,334,338	6,601	40,340,939	1,339,736.00	30.11	3.00
4.00	Subtotal other wages & related costs (see inst.)		11,561,493	0	11,561,493	251,882.00	45.90	4.00
5.00	Subtotal wage-related costs (see inst.)		10,353,986	0	10,353,986	0.00	25.67	5.00
6.00	Total (sum of lines 3 thru 5)		62,249,817	6,601	62,256,418	1,591,618.00	39.12	6.00
7.00	Total overhead cost (see instructions)		11,186,882	45,341	11,232,223	457,971.00	24.53	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/20/2015 6:15 pm

		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)	2,469,638	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)	4,403,001	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	104,312	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24,023	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)	233,556	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	574,127	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	3,103,956	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	86,396	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	102,611	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,101,620	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: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 5/20/2015 6:15 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3,650,861	11,101,619	1.00
2.00	Hospital	3,630,131	10,353,986	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	20,730	737,656	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	9,977	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/20/2015 6:15 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	523	0	523	12.00
13.00		RUB	4,723	0	4,723	13.00
14.00		RUA	2,000	0	2,000	14.00
15.00		RVC	283	0	283	15.00
16.00		RVB	1,931	0	1,931	16.00
17.00		RVA	748	0	748	17.00
18.00		RHC	9	0	9	18.00
19.00		RHB	164	0	164	19.00
20.00		RHA	85	0	85	20.00
21.00		RMC	3	0	3	21.00
22.00		RMB	7	0	7	22.00
23.00		RMA	13	0	13	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	1	0	1	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	1	0	1	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	21	0	21	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	9	0	9	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	1	0	1	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	24	0	24	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	2	0	2	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	7	0	7	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	26	0	26	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	41	0	41	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	19	0	19	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/20/2015 6:15 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	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	6	0	6	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	2	0	2	199.00
200.00	TOTAL		10,653	0	10,653	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		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	2,864,163	24.03		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)	11,921,033			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/20/2015 6:15 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.171357	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	13,380,564	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	107,416,126	6.00
7.00	Medicaid cost (line 1 times line 6)	18,406,505	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)	5,025,941	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)	5,025,941	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	14,682,382	435,581	15,117,963	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,515,929	74,640	2,590,569	21.00
22.00	Partial payment by patients approved for charity care	39,832	74,640	114,472	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,476,097	0	2,476,097	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		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)	3,500,314	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	1,093,570	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,406,744	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	412,412	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,888,509	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,914,450	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	4,898,005	4,898,005	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,257,249	2,257,249	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,620	164,894	178,514	-49,823	128,691	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,489,007	25,470,898	27,959,905	-5,940,632	22,019,273	5.00
7.00	00700	OPERATION OF PLANT	1,435,568	3,858,091	5,293,659	-475	5,293,184	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	564,599	564,599	-275	564,324	8.00
9.00	00900	HOUSEKEEPING	980,568	1,015,179	1,995,747	-30,030	1,965,717	9.00
10.00	01000	DIETARY	1,175,203	1,877,928	3,053,131	-1,293,619	1,759,512	10.00
11.00	01100	CAFETERIA	0	0	0	1,063,790	1,063,790	11.00
13.00	01300	NURSING ADMINISTRATION	941,222	251,245	1,192,467	-4,750	1,187,717	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	316,482	219,603	536,085	288,181	824,266	14.00
15.00	01500	PHARMACY	1,777,380	4,730,399	6,507,779	-4,177,525	2,330,254	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,964,587	1,224,381	3,188,968	-93,250	3,095,718	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	1,387,451	1,387,451	0	1,387,451	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	38,740	38,740	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	118,189	118,189	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,078,129	3,276,352	12,354,481	-615,339	11,739,142	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,165,441	1,857,161	6,022,602	-536,546	5,486,056	34.00
44.00	04400	SKILLED NURSING FACILITY	2,864,163	965,965	3,830,128	-135,998	3,694,130	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,154,960	5,024,428	7,179,388	-4,081,764	3,097,624	50.00
51.00	05100	RECOVERY ROOM	404,937	95,487	500,424	-19,594	480,830	51.00
53.00	05300	ANESTHESIOLOGY	68,894	803,317	872,211	-83,516	788,695	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,822,386	510,145	2,332,531	-18,286	2,314,245	54.00
56.00	05600	RADIOISOTOPE	183,447	248,607	432,054	-8,491	423,563	56.00
57.00	05700	CT SCAN	555,628	317,884	873,512	-108,711	764,801	57.00
58.00	05800	MRI	228,296	77,585	305,881	196	306,077	58.00
59.00	05900	CARDIAC CATHETERIZATION	574,992	1,463,934	2,038,926	-1,319,683	719,243	59.00
60.00	06000	LABORATORY	0	6,081,986	6,081,986	-385,323	5,696,663	60.00
65.00	06500	RESPIRATORY THERAPY	1,258,414	524,881	1,783,295	-96,845	1,686,450	65.00
66.00	06600	PHYSICAL THERAPY	1,833,208	501,348	2,334,556	-83,722	2,250,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	695,218	154,799	850,017	-6,804	843,213	67.00
68.00	06800	SPEECH PATHOLOGY	167,185	36,585	203,770	0	203,770	68.00
69.00	06900	ELECTROCARDIOLOGY	490,012	180,242	670,254	-22,405	647,849	69.00
69.01	03160	CARDIOPULMONARY	230,037	51,127	281,164	-1,179	279,985	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	36,662	221,052	257,714	-179	257,535	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,382,936	5,382,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,765,664	2,765,664	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,735,423	4,735,423	73.00
74.00	07400	RENAL DIALYSIS	301,853	99,032	400,885	-41,178	359,707	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,123,091	893,648	2,016,739	-350,464	1,666,275	90.00
91.00	09100	EMERGENCY	3,774,666	3,615,763	7,390,429	-947,618	6,442,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,094,349	1,094,349	-1,094,349	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,105,256	68,860,345	111,965,601	0	111,965,601	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,635	43,635	0	43,635	190.00
200.00		TOTAL (SUM OF LINES 118-199)	43,105,256	68,903,980	112,009,236	0	112,009,236	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	122,490	5,020,495		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	436,115	2,693,364		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	652,233	780,924		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,843,316	17,175,957		5.00
7.00	00700	OPERATION OF PLANT	0	5,293,184		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	564,324		8.00
9.00	00900	HOUSEKEEPING	0	1,965,717		9.00
10.00	01000	DIETARY	0	1,759,512		10.00
11.00	01100	CAFETERIA	-329,784	734,006		11.00
13.00	01300	NURSING ADMINISTRATION	-23,852	1,163,865		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	750,302	1,574,568		14.00
15.00	01500	PHARMACY	-548	2,329,706		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-117,384	2,978,334		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
17.01	01701	HOUSE STAFF PHYSICIANS	-1,387,451	0		17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	38,740		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	118,189		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	11,739,142		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	412,441	5,898,497		34.00
44.00	04400	SKILLED NURSING FACILITY	-10,610	3,683,520		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,097,624		50.00
51.00	05100	RECOVERY ROOM	0	480,830		51.00
53.00	05300	ANESTHESIOLOGY	-699,939	88,756		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,550	2,312,695		54.00
56.00	05600	RADIOISOTOPE	0	423,563		56.00
57.00	05700	CT SCAN	0	764,801		57.00
58.00	05800	MRI	0	306,077		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	719,243		59.00
60.00	06000	LABORATORY	-150,159	5,546,504		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,686,450		65.00
66.00	06600	PHYSICAL THERAPY	0	2,250,834		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	843,213		67.00
68.00	06800	SPEECH PATHOLOGY	0	203,770		68.00
69.00	06900	ELECTROCARDIOLOGY	0	647,849		69.00
69.01	03160	CARDIOPULMONARY	-7,945	272,040		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-198,500	59,035		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,382,936		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,765,664		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,735,423		73.00
74.00	07400	RENAL DIALYSIS	0	359,707		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-25,000	1,641,275		90.00
91.00	09100	EMERGENCY	-1,245,521	5,197,290		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,667,978	105,297,623		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,635		190.00
200.00		TOTAL (SUM OF LINES 118-199)	-6,667,978	105,341,258		200.00

RECLASSIFICATIONS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/20/2015 6:15 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - SHARED FOOD COSTS					
1.00	CAFETERIA	11.00	409,471	654,319		1.00
	TOTALS		409,471	654,319		
	B - CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,382,936		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	292,150		2.00
3.00	PHARMACY	15.00	0	18,190		3.00
4.00	MRI	58.00	0	196		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
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
	TOTALS		0	5,693,472		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,655,547		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,257,249		2.00
	TOTALS		0	5,912,796		
	D - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,735,423		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
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
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
	TOTALS		0	4,735,423		
	E - TEACHING COSTS					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	118,189		1.00
	TOTALS		0	118,189		
	F - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	148,109		1.00
	TOTALS		0	148,109		
	G - RESIDENT SALARIES					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	38,740	0		1.00
	TOTALS		38,740	0		

RECLASSIFICATIONS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/20/2015 6:15 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	H - IMPLANT RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,765,664	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	2,765,664	
	I - INTEREST				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,094,349	1.00
	TOTALS		0	1,094,349	
	J - RECLASS EHR FROM MED REC TO ADM				
1.00	ADMINISTRATIVE & GENERAL	5.00	93,245	0	1.00
	TOTALS		93,245	0	
	K - RETENTION AWARD TO SALARIES				
1.00	ADMINISTRATIVE & GENERAL	5.00	45,341	0	1.00
	TOTALS		45,341	0	
500.00	Grand Total: Increases		586,797	21,122,321	500.00

RECLASSIFICATIONS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/20/2015 6:15 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SHARED FOOD COSTS						
1.00	DIETARY	10.00	409,471	654,319	0		1.00
	TOTALS		409,471	654,319			
	B - CHARGEABLE MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,482	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	18,313	0		2.00
3.00	OPERATION OF PLANT	7.00	0	444	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	275	0		4.00
5.00	HOUSEKEEPING	9.00	0	30,022	0		5.00
6.00	DIETARY	10.00	0	229,829	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	2,770	0		7.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	5	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	480,243	0		11.00
12.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	468,618	0		12.00
13.00	SKILLED NURSING FACILITY	44.00	0	120,737	0		13.00
14.00	OPERATING ROOM	50.00	0	2,024,348	0		14.00
15.00	RECOVERY ROOM	51.00	0	12,003	0		15.00
16.00	ANESTHESIOLOGY	53.00	0	78,599	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,714	0		17.00
18.00	RADIOISOTOPE	56.00	0	7,492	0		18.00
19.00	CT SCAN	57.00	0	81,786	0		19.00
21.00	CARDIAC CATHETERIZATION	59.00	0	659,908	0		21.00
22.00	LABORATORY	60.00	0	385,323	0		22.00
23.00	RESPIRATORY THERAPY	65.00	0	96,630	0		23.00
24.00	PHYSICAL THERAPY	66.00	0	44,000	0		24.00
25.00	OCCUPATIONAL THERAPY	67.00	0	6,804	0		25.00
26.00	ELECTROCARDIOLOGY	69.00	0	16,778	0		26.00
27.00	CARDIOPULMONARY	69.01	0	1,179	0		27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	179	0		28.00
29.00	CLINIC	90.00	0	283,321	0		29.00
30.00	EMERGENCY	91.00	0	588,633	0		30.00
31.00	RENAL DIALYSIS	74.00	0	33,037	0		31.00
	TOTALS		0	5,693,472			
	C - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,912,796	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	5,912,796			
	D - DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,969	0		1.00
2.00	PHARMACY	15.00	0	4,195,715	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	135,096	0		3.00
4.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	65,428	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	15,261	0		5.00
6.00	OPERATING ROOM	50.00	0	47,947	0		6.00
7.00	RECOVERY ROOM	51.00	0	7,591	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	4,917	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	572	0		9.00
10.00	RADIOISOTOPE	56.00	0	999	0		10.00
11.00	CT SCAN	57.00	0	26,925	0		11.00
13.00	CARDIAC CATHETERIZATION	59.00	0	6,000	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	215	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	8	0		15.00
17.00	ELECTROCARDIOLOGY	69.00	0	5,627	0		17.00
18.00	RENAL DIALYSIS	74.00	0	8,141	0		18.00
19.00	CLINIC	90.00	0	11,230	0		19.00
20.00	EMERGENCY	91.00	0	199,743	0		20.00
21.00	OPERATION OF PLANT	7.00	0	31	0		21.00
22.00	HOUSEKEEPING	9.00	0	8	0		22.00
	TOTALS		0	4,735,423			
	E - TEACHING COSTS						
1.00	EMERGENCY	91.00	0	118,189	0		1.00
	TOTALS		0	118,189			
	F - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	148,109	12		1.00
	TOTALS		0	148,109			
	G - RESIDENT SALARIES						
1.00	EMERGENCY	91.00	38,740	0	0		1.00
	TOTALS		38,740	0			
	H - IMPLANT RECLASS						
1.00	NURSING ADMINISTRATION	13.00	0	1,980	0		1.00
2.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	2,500	0		2.00
3.00	OPERATING ROOM	50.00	0	2,009,469	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	653,775	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	39,714	0		5.00

RECLASSIFICATIONS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/20/2015 6:15 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
6.00	CLINIC	90.00	0	55,913	0		6.00
7.00	EMERGENCY	91.00	0	2,313	0		7.00
	TOTALS		0	2,765,664			
	I - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,094,349	11		1.00
	TOTALS		0	1,094,349			
	J - RECLASS EHR FROM MED REC TO ADM						
1.00	MEDICAL RECORDS & LIBRARY	16.00	93,245	0	0		1.00
	TOTALS		93,245	0			
	K - RETENTION AWARD TO SALARIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45,341	0		1.00
	TOTALS		0	45,341			
500.00	Grand Total: Decreases		541,456	21,167,662			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/20/2015 6:15 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,760,349	0	0	0	0	1.00
2.00	Land Improvements	2,520,848	0	0	0	0	2.00
3.00	Buildings and Fixtures	72,590,206	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	47,665,175	2,315,261	0	2,315,261	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	124,536,578	2,315,261	0	2,315,261	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	124,536,578	2,315,261	0	2,315,261	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,760,349	0	1.00
2.00	Land Improvements	2,520,848	0	2.00
3.00	Buildings and Fixtures	72,590,206	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	49,980,436	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	126,851,839	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	126,851,839	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/20/2015 6:15 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/20/2015 6:15 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	76,871,403	0	76,871,403	0.605994	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	49,980,436	0	49,980,436	0.394006	0	2.00
3.00	Total (sum of lines 1-2)	126,851,839	0	126,851,839	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,810,813	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,693,364	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,504,177	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,061,573	148,109	0	0	5,020,495	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,693,364	2.00
3.00	Total (sum of lines 1-2)	1,061,573	148,109	0	0	7,713,859	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/20/2015 6:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-32,776	CAP REL COSTS-BLDG & FIXT	1.00	11	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)	A	-9,768	ADMINISTRATIVE & GENERAL	5.00	9	7.00
8.00	Television and radio service (chapter 21)	A	-4,102	ADMINISTRATIVE & GENERAL	5.00	10	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,692,951			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-2,050,595			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-329,784	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	B	-548	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,404	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	EMPLOYEE DAY CARE REVENUE	B	-62,274	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.03	HOUSE STAFF PHYSICIANS	A	-1,387,451	HOUSE STAFF PHYSICIANS	17.01	0	33.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/20/2015 6:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.20	FITNESS CENTER REVENUE	B	-5,548	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.36	PATIENT TRANSPORTATION	B	-5,090	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.42	MISC INCOME	B	-54,373	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43	CARDIAC REHAB MISC REVENUE	B	-7,945	CARDIOPULMONARY	69.01	0	33.43
33.45			0		0.00	0	33.45
34.00	ER PHYSICAN MISC EXPENSE	A	-17	EMERGENCY	91.00	0	34.00
36.00	OLR 5K	B	-20,032	NURSING ADMINISTRATION	13.00	0	36.00
38.00	EDUCATION	B	-3,320	NURSING ADMINISTRATION	13.00	0	38.00
40.00			0		0.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,667,978				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: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/20/2015 6:15 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	5,217,281	14,114,228	1.00
2.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	750,302	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	720,055	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	DATA PROCESSING	1,475,020	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	PURCHASING	197,312	0	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	CASHIERING	2,721,933	0	3.03
3.04	34.00	SURGICAL INTENSIVE CARE UNIT	ICU	462,841	0	3.04
3.05	2.00	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION	436,115	0	3.05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	155,266	0	3.06
3.07	60.00	LABORATORY	LAB	5,525,246	5,597,738	3.07
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,661,371	19,711,966	5.00

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

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

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

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

6.00	B		0.00	RESURRECTION HEALTH CARE	100.00	6.00
7.00	C		0.00	ALVERNO LAB	66.67	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: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/20/2015 6:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-8,896,947	0		1.00
2.00	750,302	0		2.00
3.00	720,055	0		3.00
3.01	1,475,020	0		3.01
3.02	197,312	0		3.02
3.03	2,721,933	0		3.03
3.04	462,841	0		3.04
3.05	436,115	9		3.05
3.06	155,266	9		3.06
3.07	-72,492	0		3.07
4.00	0	0		4.00
5.00	-2,050,595			5.00

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

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

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

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

6.00	SOLE CORPORATE MEMBER		6.00
7.00	RELATED LAB		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: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/20/2015 6:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	699,939	699,939	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	19,500	0	19,500	154,100	120	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	1,284,244	1,245,504	38,740	177,200	484	4.00
5.00	90.00	CLINIC	25,000	25,000	0	0	0	5.00
6.00	60.00	LABORATORY	77,667	77,667	0	0	0	6.00
7.00	34.00	SURGICAL INTENSIVE CARE UNIT	50,400	50,400	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	1,550	1,550	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	267,301	267,301	0	0	0	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	198,500	198,500	0	0	0	10.00
11.00	16.00	MEDICAL RECORDS & LIBRARY	115,980	115,980	0	0	0	11.00
12.00	13.00	NURSING ADMINISTRATION	500	500	0	0	0	12.00
200.00			2,740,581	2,682,341	58,240		604	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	8,890	445	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	41,233	2,062	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	10.00
11.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	11.00
12.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	12.00
200.00			50,123	2,507	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	699,939		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	8,890	10,610	10,610		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0		3.00
4.00	91.00	EMERGENCY	0	41,233	0	1,245,504		4.00
5.00	90.00	CLINIC	0	0	0	25,000		5.00
6.00	60.00	LABORATORY	0	0	0	77,667		6.00
7.00	34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	50,400		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,550		8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	267,301		9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	198,500		10.00
11.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	115,980		11.00
12.00	13.00	NURSING ADMINISTRATION	0	0	0	500		12.00
200.00			0	50,123	10,610	2,692,951		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,020,495	5,020,495				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,693,364		2,693,364			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	780,924	0	2,223	783,147		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,175,957	1,695,724	1,326,249	47,704	20,245,634	5.00
7.00	00700	OPERATION OF PLANT	5,293,184	426,629	125,667	26,063	5,871,543	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	564,324	0	0	0	564,324	8.00
9.00	00900	HOUSEKEEPING	1,965,717	88,320	2,351	17,802	2,074,190	9.00
10.00	01000	DIETARY	1,759,512	117,416	26,462	13,902	1,917,292	10.00
11.00	01100	CAFETERIA	734,006	115,168	0	7,434	856,608	11.00
13.00	01300	NURSING ADMINISTRATION	1,163,865	37,321	3,246	17,088	1,221,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,574,568	112,412	20,314	5,746	1,713,040	14.00
15.00	01500	PHARMACY	2,329,706	39,438	4,261	32,268	2,405,673	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,978,334	98,836	2,539	33,974	3,113,683	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	38,740	0	0	703	39,443	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	118,189	0	0	0	118,189	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,739,142	794,963	33,721	164,808	12,732,634	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,898,497	106,146	15,851	75,624	6,096,118	34.00
44.00	04400	SKILLED NURSING FACILITY	3,683,520	288,805	1,964	51,999	4,026,288	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,097,624	275,649	207,716	39,123	3,620,112	50.00
51.00	05100	RECOVERY ROOM	480,830	20,365	913	7,352	509,460	51.00
53.00	05300	ANESTHESIOLOGY	88,756	8,398	40,905	1,251	139,310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,312,695	145,875	653,858	33,085	3,145,513	54.00
56.00	05600	RADIOISOTOPE	423,563	8,920	0	3,330	435,813	56.00
57.00	05700	CT SCAN	764,801	16,216	0	10,087	791,104	57.00
58.00	05800	MRI	306,077	4,337	0	4,145	314,559	58.00
59.00	05900	CARDIAC CATHETERIZATION	719,243	63,241	71,997	10,439	864,920	59.00
60.00	06000	LABORATORY	5,546,504	139,826	17,692	0	5,704,022	60.00
65.00	06500	RESPIRATORY THERAPY	1,686,450	29,459	27,754	22,847	1,766,510	65.00
66.00	06600	PHYSICAL THERAPY	2,250,834	70,580	6,224	33,282	2,360,920	66.00
67.00	06700	OCCUPATIONAL THERAPY	843,213	17,841	740	12,622	874,416	67.00
68.00	06800	SPEECH PATHOLOGY	203,770	11,749	310	3,035	218,864	68.00
69.00	06900	ELECTROCARDIOLOGY	647,849	21,380	43,087	8,896	721,212	69.00
69.01	03160	CARDIOPULMONARY	272,040	25,746	4,252	4,176	306,214	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	59,035	0	1,506	666	61,207	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,382,936	0	0	0	5,382,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,765,664	0	0	0	2,765,664	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,735,423	0	0	0	4,735,423	73.00
74.00	07400	RENAL DIALYSIS	359,707	0	0	5,480	365,187	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,641,275	66,200	9,057	20,390	1,736,922	90.00
91.00	09100	EMERGENCY	5,197,290	152,721	42,505	67,826	5,460,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	105,297,623	4,999,681	2,693,364	783,147	105,276,809	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,635	20,814	0	0	64,449	190.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	105,341,258	5,020,495	2,693,364	783,147	105,341,258	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,245,634					5.00
7.00	00700	OPERATION OF PLANT	1,396,934	7,268,477				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	134,262	0	698,586			8.00
9.00	00900	HOUSEKEEPING	493,483	221,504	0	2,789,177		9.00
10.00	01000	DIETARY	456,154	294,477	0	116,553	2,784,476	10.00
11.00	01100	CAFETERIA	203,801	288,839	0	114,322	0	11.00
13.00	01300	NURSING ADMINISTRATION	290,619	93,600	0	37,047	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	407,560	281,927	0	111,586	0	14.00
15.00	01500	PHARMACY	572,348	98,911	0	39,149	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	740,795	247,877	0	98,109	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	9,384	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	28,119	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,029,319	1,993,750	291,119	789,121	1,786,604	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,450,364	266,212	68,784	105,366	211,063	34.00
44.00	04400	SKILLED NURSING FACILITY	957,918	724,316	76,315	286,683	786,809	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	861,283	691,321	54,422	273,623	0	50.00
51.00	05100	RECOVERY ROOM	121,209	51,074	0	20,215	0	51.00
53.00	05300	ANESTHESIOLOGY	33,144	21,063	0	8,337	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	748,368	365,850	59,143	144,803	0	54.00
56.00	05600	RADIOISOTOPE	103,687	22,372	0	8,855	0	56.00
57.00	05700	CT SCAN	188,216	40,670	0	16,097	0	57.00
58.00	05800	MRI	74,839	10,877	0	4,305	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	205,778	158,607	3,985	62,776	0	59.00
60.00	06000	LABORATORY	1,357,078	350,681	0	138,799	0	60.00
65.00	06500	RESPIRATORY THERAPY	420,281	73,883	0	29,243	0	65.00
66.00	06600	PHYSICAL THERAPY	561,701	177,014	14,687	70,062	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	208,038	44,745	0	17,710	0	67.00
68.00	06800	SPEECH PATHOLOGY	52,071	29,466	0	11,663	0	68.00
69.00	06900	ELECTROCARDIOLOGY	171,588	53,621	3,883	21,223	0	69.00
69.01	03160	CARDIOPULMONARY	72,853	64,570	0	25,557	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	14,562	0	103	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,280,687	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	657,996	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,126,633	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	86,884	0	1,621	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	413,242	166,028	3,495	65,713	0	90.00
91.00	09100	EMERGENCY	1,299,103	383,020	117,964	151,599	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,230,301	7,216,275	695,521	2,768,516	2,784,476	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,333	52,202	3,065	20,661	0	190.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,245,634	7,268,477	698,586	2,789,177	2,784,476	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,463,570					11.00
13.00	01300	NURSING ADMINISTRATION	28,719	1,671,505				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,298	0	2,533,411			14.00
15.00	01500	PHARMACY	56,502	0	0	3,172,583		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84,713	0	0	0	4,285,177	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	546,367	900,655	0	0	571,144	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	562	927	0	0	170,089	34.00
44.00	04400	SKILLED NURSING FACILITY	138,244	227,888	0	0	83,376	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,778	115,025	0	0	195,912	50.00
51.00	05100	RECOVERY ROOM	11,001	18,134	0	0	36,363	51.00
53.00	05300	ANESTHESIOLOGY	2,864	0	0	0	48,595	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,970	0	0	0	201,487	54.00
56.00	05600	RADIOISOTOPE	5,166	0	0	0	45,525	56.00
57.00	05700	CT SCAN	18,789	0	0	0	294,925	57.00
58.00	05800	MRI	6,852	0	0	0	63,026	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,836	27,753	0	0	118,703	59.00
60.00	06000	LABORATORY	0	0	0	0	535,297	60.00
65.00	06500	RESPIRATORY THERAPY	55,084	0	0	0	205,398	65.00
66.00	06600	PHYSICAL THERAPY	66,887	0	0	0	87,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,410	0	0	0	40,738	67.00
68.00	06800	SPEECH PATHOLOGY	5,326	0	0	0	7,117	68.00
69.00	06900	ELECTROCARDIOLOGY	21,466	35,386	0	0	137,149	69.00
69.01	03160	CARDIOPULMONARY	6,986	11,516	0	0	4,461	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,061	3,397	0	0	2,103	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,673,563	0	95,438	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	859,848	0	83,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,172,583	677,186	73.00
74.00	07400	RENAL DIALYSIS	8,244	13,589	0	0	17,612	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44,244	72,933	0	0	75,959	90.00
91.00	09100	EMERGENCY	148,201	244,302	0	0	487,267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,463,570	1,671,505	2,533,411	3,172,583	4,285,177	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,463,570	1,671,505	2,533,411	3,172,583	4,285,177	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	SOCIAL SERVICE	HOUSE STAFF PHYSICIANS	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			17.00	17.01	21.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	48,827			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	146,308		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	12,207	36,577	22,689,497	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	12,207	36,577	8,418,269	34.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	7,307,837	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	5,881,476	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	767,456	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	253,313	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	4,740,134	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	621,418	56.00
57.00	05700	CT SCAN	0	0	0	0	1,349,801	57.00
58.00	05800	MRI	0	0	0	0	474,458	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	1,459,358	59.00
60.00	06000	LABORATORY	0	0	0	0	8,085,877	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	2,550,399	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,338,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,210,057	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	324,507	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,165,528	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	492,157	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	83,433	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	8,432,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,366,513	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,711,825	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	493,137	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	2,578,536	90.00
91.00	09100	EMERGENCY	0	0	24,413	73,154	8,389,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	48,827	146,308	105,185,548	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	155,710	190.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	48,827	146,308	105,341,258	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	HOUSE STAFF PHYSICIANS				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-48,784	22,640,713		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-48,784	8,369,485		34.00
44.00	04400	SKILLED NURSING FACILITY	0	7,307,837		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,881,476		50.00
51.00	05100	RECOVERY ROOM	0	767,456		51.00
53.00	05300	ANESTHESIOLOGY	0	253,313		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,740,134		54.00
56.00	05600	RADIOISOTOPE	0	621,418		56.00
57.00	05700	CT SCAN	0	1,349,801		57.00
58.00	05800	MRI	0	474,458		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,459,358		59.00
60.00	06000	LABORATORY	0	8,085,877		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,550,399		65.00
66.00	06600	PHYSICAL THERAPY	0	3,338,573		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,210,057		67.00
68.00	06800	SPEECH PATHOLOGY	0	324,507		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,165,528		69.00
69.01	03160	CARDIOPULMONARY	0	492,157		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	83,433		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,432,624		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,366,513		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,711,825		73.00
74.00	07400	RENAL DIALYSIS	0	493,137		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	2,578,536		90.00
91.00	09100	EMERGENCY	-97,567	8,291,798		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-195,135	104,990,413		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	155,710		190.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	-195,135	105,146,123		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	802	0	2,223	3,025	3,025	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,397	1,695,724	1,326,249	3,067,370	184	5.00
7.00	00700	OPERATION OF PLANT	13,598	426,629	125,667	565,894	100	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	122	0	0	122	0	8.00
9.00	00900	HOUSEKEEPING	13,675	88,320	2,351	104,346	69	9.00
10.00	01000	DIETARY	25,820	117,416	26,462	169,698	54	10.00
11.00	01100	CAFETERIA	0	115,168	0	115,168	29	11.00
13.00	01300	NURSING ADMINISTRATION	7,785	37,321	3,246	48,352	66	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,415	112,412	20,314	238,141	22	14.00
15.00	01500	PHARMACY	1,938	39,438	4,261	45,637	124	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,830	98,836	2,539	114,205	131	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	3	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,999	794,963	33,721	852,683	639	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,745	106,146	15,851	129,742	292	34.00
44.00	04400	SKILLED NURSING FACILITY	9,352	288,805	1,964	300,121	200	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	141,523	275,649	207,716	624,888	151	50.00
51.00	05100	RECOVERY ROOM	300	20,365	913	21,578	28	51.00
53.00	05300	ANESTHESIOLOGY	77	8,398	40,905	49,380	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	145,875	653,858	799,733	128	54.00
56.00	05600	RADIOISOTOPE	156	8,920	0	9,076	13	56.00
57.00	05700	CT SCAN	0	16,216	0	16,216	39	57.00
58.00	05800	MRI	0	4,337	0	4,337	16	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,281	63,241	71,997	139,519	40	59.00
60.00	06000	LABORATORY	0	139,826	17,692	157,518	0	60.00
65.00	06500	RESPIRATORY THERAPY	39,846	29,459	27,754	97,059	88	65.00
66.00	06600	PHYSICAL THERAPY	8,419	70,580	6,224	85,223	128	66.00
67.00	06700	OCCUPATIONAL THERAPY	874	17,841	740	19,455	49	67.00
68.00	06800	SPEECH PATHOLOGY	91	11,749	310	12,150	12	68.00
69.00	06900	ELECTROCARDIOLOGY	11,804	21,380	43,087	76,271	34	69.00
69.01	03160	CARDIOPULMONARY	0	25,746	4,252	29,998	16	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	722	0	1,506	2,228	3	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	300	0	0	300	21	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,538	66,200	9,057	90,795	79	90.00
91.00	09100	EMERGENCY	11,644	152,721	42,505	206,870	262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	504,053	4,999,681	2,693,364	8,197,098	3,025	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	108	20,814	0	20,922	0	190.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	504,161	5,020,495	2,693,364	8,218,020	3,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,067,554					5.00
7.00	00700	OPERATION OF PLANT	211,657	777,651				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,343	0	20,465			8.00
9.00	00900	HOUSEKEEPING	74,770	23,699	0	202,884		9.00
10.00	01000	DIETARY	69,115	31,506	0	8,478	278,851	10.00
11.00	01100	CAFETERIA	30,879	30,903	0	8,316	0	11.00
13.00	01300	NURSING ADMINISTRATION	44,033	10,014	0	2,695	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	61,752	30,163	0	8,117	0	14.00
15.00	01500	PHARMACY	86,720	10,582	0	2,848	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,242	26,520	0	7,136	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,422	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	4,260	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	459,013	213,312	8,528	57,403	178,919	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	219,753	28,482	2,015	7,664	21,137	34.00
44.00	04400	SKILLED NURSING FACILITY	145,140	77,494	2,236	20,853	78,795	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	130,498	73,964	1,594	19,903	0	50.00
51.00	05100	RECOVERY ROOM	18,365	5,464	0	1,470	0	51.00
53.00	05300	ANESTHESIOLOGY	5,022	2,253	0	606	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,389	39,142	1,733	10,533	0	54.00
56.00	05600	RADIOISOTOPE	15,710	2,394	0	644	0	56.00
57.00	05700	CT SCAN	28,518	4,351	0	1,171	0	57.00
58.00	05800	MRI	11,339	1,164	0	313	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,179	16,969	117	4,566	0	59.00
60.00	06000	LABORATORY	205,619	37,519	0	10,096	0	60.00
65.00	06500	RESPIRATORY THERAPY	63,679	7,905	0	2,127	0	65.00
66.00	06600	PHYSICAL THERAPY	85,106	18,939	430	5,096	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,521	4,787	0	1,288	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,890	3,153	0	848	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,998	5,737	114	1,544	0	69.00
69.01	03160	CARDIOPULMONARY	11,038	6,908	0	1,859	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,206	0	3	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	194,044	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	99,697	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,703	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	13,164	0	47	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62,613	17,763	102	4,780	0	90.00
91.00	09100	EMERGENCY	196,834	40,979	3,456	11,027	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,065,231	772,066	20,375	201,381	278,851	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,323	5,585	90	1,503	0	190.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,067,554	777,651	20,465	202,884	278,851	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	185,295					11.00
13.00	01300	NURSING ADMINISTRATION	3,636	108,796				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,443	0	340,638			14.00
15.00	01500	PHARMACY	7,153	0	0	153,064		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,725	0	0	0	270,959	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	69,175	58,623	0	0	36,095	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	71	60	0	0	10,749	34.00
44.00	04400	SKILLED NURSING FACILITY	17,502	14,833	0	0	5,269	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,834	7,487	0	0	12,381	50.00
51.00	05100	RECOVERY ROOM	1,393	1,180	0	0	2,298	51.00
53.00	05300	ANESTHESIOLOGY	363	0	0	0	3,071	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,492	0	0	0	12,733	54.00
56.00	05600	RADIOISOTOPE	654	0	0	0	2,877	56.00
57.00	05700	CT SCAN	2,379	0	0	0	18,638	57.00
58.00	05800	MRI	867	0	0	0	3,983	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,131	1,806	0	0	7,502	59.00
60.00	06000	LABORATORY	0	0	0	0	33,829	60.00
65.00	06500	RESPIRATORY THERAPY	6,974	0	0	0	12,981	65.00
66.00	06600	PHYSICAL THERAPY	8,468	0	0	0	5,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,090	0	0	0	2,574	67.00
68.00	06800	SPEECH PATHOLOGY	674	0	0	0	450	68.00
69.00	06900	ELECTROCARDIOLOGY	2,718	2,303	0	0	8,667	69.00
69.01	03160	CARDIOPULMONARY	884	750	0	0	282	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	261	221	0	0	133	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	225,025	0	6,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	115,613	0	5,246	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	153,064	42,946	73.00
74.00	07400	RENAL DIALYSIS	1,044	885	0	0	1,113	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,601	4,747	0	0	4,800	90.00
91.00	09100	EMERGENCY	18,763	15,901	0	0	30,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	185,295	108,796	340,638	153,064	270,959	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	185,295	108,796	340,638	153,064	270,959	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	SOCIAL SERVICE	HOUSE STAFF PHYSICIANS	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			17.00	17.01	21.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,425			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		4,260		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0			1,934,390	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0			419,965	34.00
44.00	04400	SKILLED NURSING FACILITY	0	0			662,443	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0			879,700	50.00
51.00	05100	RECOVERY ROOM	0	0			51,776	51.00
53.00	05300	ANESTHESIOLOGY	0	0			60,700	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			986,883	54.00
56.00	05600	RADIOISOTOPE	0	0			31,368	56.00
57.00	05700	CT SCAN	0	0			71,312	57.00
58.00	05800	MRI	0	0			22,019	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0			203,829	59.00
60.00	06000	LABORATORY	0	0			444,581	60.00
65.00	06500	RESPIRATORY THERAPY	0	0			190,813	65.00
66.00	06600	PHYSICAL THERAPY	0	0			208,907	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			62,764	67.00
68.00	06800	SPEECH PATHOLOGY	0	0			25,177	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			123,386	69.00
69.01	03160	CARDIOPULMONARY	0	0			51,735	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			5,055	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			425,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			220,556	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			366,713	73.00
74.00	07400	RENAL DIALYSIS	0	0			16,574	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0			191,280	90.00
91.00	09100	EMERGENCY	0	0			524,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	8,181,912	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			30,423	190.00
200.00		Cross Foot Adjustments			1,425	4,260	5,685	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	1,425	4,260	8,218,020	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01701	HOUSE STAFF PHYSICIANS				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,934,390		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	419,965		34.00
44.00	04400	SKILLED NURSING FACILITY	0	662,443		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	879,700		50.00
51.00	05100	RECOVERY ROOM	0	51,776		51.00
53.00	05300	ANESTHESIOLOGY	0	60,700		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	986,883		54.00
56.00	05600	RADIOISOTOPE	0	31,368		56.00
57.00	05700	CT SCAN	0	71,312		57.00
58.00	05800	MRI	0	22,019		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	203,829		59.00
60.00	06000	LABORATORY	0	444,581		60.00
65.00	06500	RESPIRATORY THERAPY	0	190,813		65.00
66.00	06600	PHYSICAL THERAPY	0	208,907		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	62,764		67.00
68.00	06800	SPEECH PATHOLOGY	0	25,177		68.00
69.00	06900	ELECTROCARDIOLOGY	0	123,386		69.00
69.01	03160	CARDIOPULMONARY	0	51,735		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,055		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	425,100		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	220,556		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	366,713		73.00
74.00	07400	RENAL DIALYSIS	0	16,574		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	191,280		90.00
91.00	09100	EMERGENCY	0	524,886		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	8,181,912		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,423		190.00
200.00		Cross Foot Adjustments	0	5,685		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	8,218,020		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	346,127					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,547,257				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,928	43,136,977			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	116,908	1,746,719	2,627,593	-20,245,634	85,095,624	5.00
7.00	00700	OPERATION OF PLANT	29,413	165,508	1,435,568	0	5,871,543	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	564,324	8.00
9.00	00900	HOUSEKEEPING	6,089	3,097	980,568	0	2,074,190	9.00
10.00	01000	DIETARY	8,095	34,852	765,732	0	1,917,292	10.00
11.00	01100	CAFETERIA	7,940	0	409,471	0	856,608	11.00
13.00	01300	NURSING ADMINISTRATION	2,573	4,275	941,222	0	1,221,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,750	26,754	316,482	0	1,713,040	14.00
15.00	01500	PHARMACY	2,719	5,612	1,777,380	0	2,405,673	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,814	3,344	1,871,342	0	3,113,683	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	38,740	0	39,443	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	118,189	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,807	44,412	9,078,129	0	12,732,634	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,318	20,876	4,165,441	0	6,096,118	34.00
44.00	04400	SKILLED NURSING FACILITY	19,911	2,586	2,864,163	0	4,026,288	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,004	273,569	2,154,960	0	3,620,112	50.00
51.00	05100	RECOVERY ROOM	1,404	1,203	404,937	0	509,460	51.00
53.00	05300	ANESTHESIOLOGY	579	53,873	68,894	0	139,310	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,057	861,154	1,822,386	0	3,145,513	54.00
56.00	05600	RADIOISOTOPE	615	0	183,447	0	435,813	56.00
57.00	05700	CT SCAN	1,118	0	555,628	0	791,104	57.00
58.00	05800	MRI	299	0	228,296	0	314,559	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,360	94,823	574,992	0	864,920	59.00
60.00	06000	LABORATORY	9,640	23,301	0	0	5,704,022	60.00
65.00	06500	RESPIRATORY THERAPY	2,031	36,553	1,258,414	0	1,766,510	65.00
66.00	06600	PHYSICAL THERAPY	4,866	8,197	1,833,208	0	2,360,920	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,230	974	695,218	0	874,416	67.00
68.00	06800	SPEECH PATHOLOGY	810	408	167,185	0	218,864	68.00
69.00	06900	ELECTROCARDIOLOGY	1,474	56,747	490,012	0	721,212	69.00
69.01	03160	CARDIOPULMONARY	1,775	5,600	230,037	0	306,214	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,983	36,662	0	61,207	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,382,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,765,664	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,735,423	73.00
74.00	07400	RENAL DIALYSIS	0	0	301,853	0	365,187	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,564	11,928	1,123,091	0	1,736,922	90.00
91.00	09100	EMERGENCY	10,529	55,981	3,735,926	0	5,460,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	344,692	3,547,257	43,136,977	-20,245,634	85,031,175	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,435	0	0	0	64,449	190.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,020,495	2,693,364	783,147		20,245,634	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.504777	0.759281	0.018155		0.237916	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,025		3,067,554	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000070		0.036048	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV ED))	CAFETERIA (FTES SERVE D)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	199,806					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,122,916				8.00
9.00	00900	HOUSEKEEPING	6,089	0	193,717			9.00
10.00	01000	DIETARY	8,095	0	8,095	123,127		10.00
11.00	01100	CAFETERIA	7,940	0	7,940	0	54,681	11.00
13.00	01300	NURSING ADMINISTRATION	2,573	0	2,573	0	1,073	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,750	0	7,750	0	721	14.00
15.00	01500	PHARMACY	2,719	0	2,719	0	2,111	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,814	0	6,814	0	3,165	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,807	467,949	54,807	79,002	20,413	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	7,318	110,564	7,318	9,333	21	34.00
44.00	04400	SKILLED NURSING FACILITY	19,911	122,670	19,911	34,792	5,165	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,004	87,478	19,004	0	2,607	50.00
51.00	05100	RECOVERY ROOM	1,404	0	1,404	0	411	51.00
53.00	05300	ANESTHESIOLOGY	579	0	579	0	107	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,057	95,067	10,057	0	2,801	54.00
56.00	05600	RADIOISOTOPE	615	0	615	0	193	56.00
57.00	05700	CT SCAN	1,118	0	1,118	0	702	57.00
58.00	05800	MRI	299	0	299	0	256	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,360	6,406	4,360	0	629	59.00
60.00	06000	LABORATORY	9,640	0	9,640	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,031	0	2,031	0	2,058	65.00
66.00	06600	PHYSICAL THERAPY	4,866	23,608	4,866	0	2,499	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,230	0	1,230	0	912	67.00
68.00	06800	SPEECH PATHOLOGY	810	0	810	0	199	68.00
69.00	06900	ELECTROCARDIOLOGY	1,474	6,241	1,474	0	802	69.00
69.01	03160	CARDIOPULMONARY	1,775	0	1,775	0	261	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	166	0	0	77	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	2,606	0	0	308	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,564	5,618	4,564	0	1,653	90.00
91.00	09100	EMERGENCY	10,529	189,617	10,529	0	5,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	198,371	1,117,990	192,282	123,127	54,681	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,435	4,926	1,435	0	0	190.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,268,477	698,586	2,789,177	2,784,476	1,463,570	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.377671	0.622118	14.398205	22.614666	26.765604	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	777,651	20,465	202,884	278,851	185,295	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.892030	0.018225	1.047322	2.264743	3.388654	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	NURSING ADMINISTRATION (FTES SERVE D)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS))	PHARMACY (COSTED REQ UIS))	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT))	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	37,884					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,148,600				14.00
15.00	01500	PHARMACY	0	0	4,735,423			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	612,699,249		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0	0	0	0	0	17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,413	0	0	81,662,049	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	21	0	0	24,319,327	0	34.00
44.00	04400	SKILLED NURSING FACILITY	5,165	0	0	11,921,033	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,607	0	0	28,011,407	0	50.00
51.00	05100	RECOVERY ROOM	411	0	0	5,199,137	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,948,069	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,808,577	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	6,509,197	0	56.00
57.00	05700	CT SCAN	0	0	0	42,168,323	0	57.00
58.00	05800	MRI	0	0	0	9,011,454	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	629	0	0	16,972,079	0	59.00
60.00	06000	LABORATORY	0	0	0	76,536,671	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	29,367,677	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,482,435	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,824,641	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,017,530	0	68.00
69.00	06900	ELECTROCARDIOLOGY	802	0	0	19,609,540	0	69.00
69.01	03160	CARDIOPULMONARY	261	0	0	637,840	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	77	0	0	300,691	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,382,936	0	13,645,736	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,765,664	0	11,868,059	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,735,423	96,829,730	0	73.00
74.00	07400	RENAL DIALYSIS	308	0	0	2,518,206	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,653	0	0	10,860,623	0	90.00
91.00	09100	EMERGENCY	5,537	0	0	69,669,218	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,884	8,148,600	4,735,423	612,699,249	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,671,505	2,533,411	3,172,583	4,285,177	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.121661	0.310901	0.669968	0.006994	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	108,796	340,638	153,064	270,959	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.871819	0.041803	0.032323	0.000442	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/20/2015 6:15 pm

		Cost Center Description	HOUSE STAFF PHYSICIANS (SQ FEET SQ FEET)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME))	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME))		
			17.01	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
17.01	01701	HOUSE STAFF PHYSICIANS	0				17.01
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	200			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		200		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	50	50		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	50	50		34.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	100	100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	200	200		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	48,827	146,308		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	244.135000	731.540000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,425	4,260		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	7.125000	21.300000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,640,713		22,640,713	0	22,640,713	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,369,485		8,369,485	0	8,369,485	34.00
44.00	04400	SKILLED NURSING FACILITY	7,307,837		7,307,837	10,610	7,318,447	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,881,476		5,881,476	0	5,881,476	50.00
51.00	05100	RECOVERY ROOM	767,456		767,456	0	767,456	51.00
53.00	05300	ANESTHESIOLOGY	253,313		253,313	0	253,313	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,740,134		4,740,134	0	4,740,134	54.00
56.00	05600	RADIOISOTOPE	621,418		621,418	0	621,418	56.00
57.00	05700	CT SCAN	1,349,801		1,349,801	0	1,349,801	57.00
58.00	05800	MRI	474,458		474,458	0	474,458	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,459,358		1,459,358	0	1,459,358	59.00
60.00	06000	LABORATORY	8,085,877		8,085,877	0	8,085,877	60.00
65.00	06500	RESPIRATORY THERAPY	2,550,399	0	2,550,399	0	2,550,399	65.00
66.00	06600	PHYSICAL THERAPY	3,338,573	0	3,338,573	0	3,338,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,210,057	0	1,210,057	0	1,210,057	67.00
68.00	06800	SPEECH PATHOLOGY	324,507	0	324,507	0	324,507	68.00
69.00	06900	ELECTROCARDIOLOGY	1,165,528		1,165,528	0	1,165,528	69.00
69.01	03160	CARDIOPULMONARY	492,157		492,157	0	492,157	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	83,433		83,433	0	83,433	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,432,624		8,432,624	0	8,432,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,366,513		4,366,513	0	4,366,513	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,711,825		9,711,825	0	9,711,825	73.00
74.00	07400	RENAL DIALYSIS	493,137		493,137	0	493,137	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,578,536		2,578,536	0	2,578,536	90.00
91.00	09100	EMERGENCY	8,291,798		8,291,798	0	8,291,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,487,225		2,487,225		2,487,225	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	107,477,638	0	107,477,638	10,610	107,488,248	200.00
201.00		Less Observation Beds	2,487,225		2,487,225		2,487,225	201.00
202.00		Total (see instructions)	104,990,413	0	104,990,413	10,610	105,001,023	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/20/2015 6:15 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,536,248		70,536,248			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	24,319,327		24,319,327			34.00
44.00	04400	SKILLED NURSING FACILITY	11,921,033		11,921,033			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,285,976	13,725,431	28,011,407	0.209967	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,078,684	2,120,453	5,199,137	0.147612	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,709,967	3,238,102	6,948,069	0.036458	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,779,683	18,028,894	28,808,577	0.164539	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,040,105	4,469,092	6,509,197	0.095468	0.000000	56.00
57.00	05700	CT SCAN	16,073,707	26,094,616	42,168,323	0.032010	0.000000	57.00
58.00	05800	MRI	2,983,372	6,028,082	9,011,454	0.052651	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,823,218	4,148,861	16,972,079	0.085986	0.000000	59.00
60.00	06000	LABORATORY	46,494,257	30,042,414	76,536,671	0.105647	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	27,993,231	1,374,446	29,367,677	0.086844	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,889,366	3,593,069	12,482,435	0.267462	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,741,378	1,083,263	5,824,641	0.207748	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	903,304	114,226	1,017,530	0.318916	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,837,487	8,772,053	19,609,540	0.059437	0.000000	69.00
69.01	03160	CARDIOPULMONARY	385,110	252,730	637,840	0.771599	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	217,729	82,962	300,691	0.277471	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,842,002	4,803,734	13,645,736	0.617968	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,051,549	4,816,510	11,868,059	0.367921	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,696,521	23,133,209	96,829,730	0.100298	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,319,626	198,580	2,518,206	0.195829	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,717,599	8,143,024	10,860,623	0.237421	0.000000	90.00
91.00	09100	EMERGENCY	16,066,087	53,603,131	69,669,218	0.119017	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,433,331	8,692,470	11,125,801	0.223555	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	386,139,897	226,559,352	612,699,249			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	386,139,897	226,559,352	612,699,249			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.209967
51.00	05100	RECOVERY ROOM	0.147612
53.00	05300	ANESTHESIOLOGY	0.036458
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164539
56.00	05600	RADIOISOTOPE	0.095468
57.00	05700	CT SCAN	0.032010
58.00	05800	MRI	0.052651
59.00	05900	CARDIAC CATHETERIZATION	0.085986
60.00	06000	LABORATORY	0.105647
65.00	06500	RESPIRATORY THERAPY	0.086844
66.00	06600	PHYSICAL THERAPY	0.267462
67.00	06700	OCCUPATIONAL THERAPY	0.207748
68.00	06800	SPEECH PATHOLOGY	0.318916
69.00	06900	ELECTROCARDIOLOGY	0.059437
69.01	03160	CARDIOPULMONARY	0.771599
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277471
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.617968
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367921
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100298
74.00	07400	RENAL DIALYSIS	0.195829
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.237421
91.00	09100	EMERGENCY	0.119017
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.223555
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/20/2015 6:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,640,713		22,640,713	0	22,640,713	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	8,369,485		8,369,485	0	8,369,485	34.00
44.00	04400	SKILLED NURSING FACILITY	7,307,837		7,307,837	10,610	7,318,447	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,881,476		5,881,476	0	5,881,476	50.00
51.00	05100	RECOVERY ROOM	767,456		767,456	0	767,456	51.00
53.00	05300	ANESTHESIOLOGY	253,313		253,313	0	253,313	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,740,134		4,740,134	0	4,740,134	54.00
56.00	05600	RADIOISOTOPE	621,418		621,418	0	621,418	56.00
57.00	05700	CT SCAN	1,349,801		1,349,801	0	1,349,801	57.00
58.00	05800	MRI	474,458		474,458	0	474,458	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,459,358		1,459,358	0	1,459,358	59.00
60.00	06000	LABORATORY	8,085,877		8,085,877	0	8,085,877	60.00
65.00	06500	RESPIRATORY THERAPY	2,550,399	0	2,550,399	0	2,550,399	65.00
66.00	06600	PHYSICAL THERAPY	3,338,573	0	3,338,573	0	3,338,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,210,057	0	1,210,057	0	1,210,057	67.00
68.00	06800	SPEECH PATHOLOGY	324,507	0	324,507	0	324,507	68.00
69.00	06900	ELECTROCARDIOLOGY	1,165,528		1,165,528	0	1,165,528	69.00
69.01	03160	CARDIOPULMONARY	492,157		492,157	0	492,157	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	83,433		83,433	0	83,433	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,432,624		8,432,624	0	8,432,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,366,513		4,366,513	0	4,366,513	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,711,825		9,711,825	0	9,711,825	73.00
74.00	07400	RENAL DIALYSIS	493,137		493,137	0	493,137	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,578,536		2,578,536	0	2,578,536	90.00
91.00	09100	EMERGENCY	8,291,798		8,291,798	0	8,291,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,487,225		2,487,225		2,487,225	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	107,477,638	0	107,477,638	10,610	107,488,248	200.00
201.00		Less Observation Beds	2,487,225		2,487,225		2,487,225	201.00
202.00		Total (see instructions)	104,990,413	0	104,990,413	10,610	105,001,023	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/20/2015 6:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,536,248		70,536,248			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	24,319,327		24,319,327			34.00
44.00	04400	SKILLED NURSING FACILITY	11,921,033		11,921,033			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,285,976	13,725,431	28,011,407	0.209967	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,078,684	2,120,453	5,199,137	0.147612	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,709,967	3,238,102	6,948,069	0.036458	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,779,683	18,028,894	28,808,577	0.164539	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,040,105	4,469,092	6,509,197	0.095468	0.000000	56.00
57.00	05700	CT SCAN	16,073,707	26,094,616	42,168,323	0.032010	0.000000	57.00
58.00	05800	MRI	2,983,372	6,028,082	9,011,454	0.052651	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,823,218	4,148,861	16,972,079	0.085986	0.000000	59.00
60.00	06000	LABORATORY	46,494,257	30,042,414	76,536,671	0.105647	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	27,993,231	1,374,446	29,367,677	0.086844	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,889,366	3,593,069	12,482,435	0.267462	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,741,378	1,083,263	5,824,641	0.207748	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	903,304	114,226	1,017,530	0.318916	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,837,487	8,772,053	19,609,540	0.059437	0.000000	69.00
69.01	03160	CARDIOPULMONARY	385,110	252,730	637,840	0.771599	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	217,729	82,962	300,691	0.277471	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,842,002	4,803,734	13,645,736	0.617968	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,051,549	4,816,510	11,868,059	0.367921	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,696,521	23,133,209	96,829,730	0.100298	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,319,626	198,580	2,518,206	0.195829	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,717,599	8,143,024	10,860,623	0.237421	0.000000	90.00
91.00	09100	EMERGENCY	16,066,087	53,603,131	69,669,218	0.119017	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,433,331	8,692,470	11,125,801	0.223555	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	386,139,897	226,559,352	612,699,249			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	386,139,897	226,559,352	612,699,249			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/20/2015 6:15 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
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
56.00	05600	RADIOISOTOPE	0.000000		56.00
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
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160	CARDIOPULMONARY	0.000000		69.01
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
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,934,390	0	1,934,390	29,584	65.39	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	419,965		419,965	6,222	67.50	34.00
44.00	SKILLED NURSING FACILITY	662,443		662,443	12,886	51.41	44.00
200.00	Total (lines 30-199)	3,016,798		3,016,798	48,692		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	13,178	861,709	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	3,034	204,795	34.00
44.00	SKILLED NURSING FACILITY	10,653	547,671	44.00
200.00	Total (lines 30-199)	26,865	1,614,175	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	879,700	28,011,407	0.031405	5,831,622	183,142	50.00
51.00	05100	RECOVERY ROOM	51,776	5,199,137	0.009959	1,172,642	11,678	51.00
53.00	05300	ANESTHESIOLOGY	60,700	6,948,069	0.008736	1,450,285	12,670	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986,883	28,808,577	0.034257	5,326,989	182,487	54.00
56.00	05600	RADIOISOTOPE	31,368	6,509,197	0.004819	1,027,533	4,952	56.00
57.00	05700	CT SCAN	71,312	42,168,323	0.001691	7,194,193	12,165	57.00
58.00	05800	MRI	22,019	9,011,454	0.002443	1,350,067	3,298	58.00
59.00	05900	CARDIAC CATHETERIZATION	203,829	16,972,079	0.012010	4,554,705	54,702	59.00
60.00	06000	LABORATORY	444,581	76,536,671	0.005809	21,787,193	126,562	60.00
65.00	06500	RESPIRATORY THERAPY	190,813	29,367,677	0.006497	9,360,212	60,813	65.00
66.00	06600	PHYSICAL THERAPY	208,907	12,482,435	0.016736	1,179,270	19,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,764	5,824,641	0.010776	380,918	4,105	67.00
68.00	06800	SPEECH PATHOLOGY	25,177	1,017,530	0.024743	438,773	10,857	68.00
69.00	06900	ELECTROCARDIOLOGY	123,386	19,609,540	0.006292	5,930,589	37,315	69.00
69.01	03160	CARDIOPULMONARY	51,735	637,840	0.081110	165,161	13,396	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	5,055	300,691	0.016811	104,478	1,756	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	425,100	13,645,736	0.031153	7,287,294	227,021	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	220,556	11,868,059	0.018584	3,057,867	56,827	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	366,713	96,829,730	0.003787	30,977,480	117,312	73.00
74.00	07400	RENAL DIALYSIS	16,574	2,518,206	0.006582	1,409,569	9,278	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	191,280	10,860,623	0.017612	1,292,276	22,760	90.00
91.00	09100	EMERGENCY	524,886	69,669,218	0.007534	7,500,344	56,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	212,506	11,125,801	0.019100	1,212,574	23,160	92.00
200.00		Total (lines 50-199)	5,377,620	505,922,641		119,992,034	1,252,500	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		0	34.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,584	0.00	13,178	0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,222	0.00	3,034	0		34.00
44.00	04400	SKILLED NURSING FACILITY	12,886	0.00	10,653	0		44.00
200.00		Total (lines 30-199)	48,692		26,865	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,011,407	0.000000	0.000000	5,831,622	50.00
51.00	05100	RECOVERY ROOM	0	5,199,137	0.000000	0.000000	1,172,642	51.00
53.00	05300	ANESTHESIOLOGY	0	6,948,069	0.000000	0.000000	1,450,285	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,808,577	0.000000	0.000000	5,326,989	54.00
56.00	05600	RADIOISOTOPE	0	6,509,197	0.000000	0.000000	1,027,533	56.00
57.00	05700	CT SCAN	0	42,168,323	0.000000	0.000000	7,194,193	57.00
58.00	05800	MRI	0	9,011,454	0.000000	0.000000	1,350,067	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,972,079	0.000000	0.000000	4,554,705	59.00
60.00	06000	LABORATORY	0	76,536,671	0.000000	0.000000	21,787,193	60.00
65.00	06500	RESPIRATORY THERAPY	0	29,367,677	0.000000	0.000000	9,360,212	65.00
66.00	06600	PHYSICAL THERAPY	0	12,482,435	0.000000	0.000000	1,179,270	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,824,641	0.000000	0.000000	380,918	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,017,530	0.000000	0.000000	438,773	68.00
69.00	06900	ELECTROCARDIOLOGY	0	19,609,540	0.000000	0.000000	5,930,589	69.00
69.01	03160	CARDIOPULMONARY	0	637,840	0.000000	0.000000	165,161	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	300,691	0.000000	0.000000	104,478	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,645,736	0.000000	0.000000	7,287,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,868,059	0.000000	0.000000	3,057,867	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	96,829,730	0.000000	0.000000	30,977,480	73.00
74.00	07400	RENAL DIALYSIS	0	2,518,206	0.000000	0.000000	1,409,569	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,860,623	0.000000	0.000000	1,292,276	90.00
91.00	09100	EMERGENCY	0	69,669,218	0.000000	0.000000	7,500,344	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	11,125,801	0.000000	0.000000	1,212,574	92.00
200.00		Total (lines 50-199)	0	505,922,641			119,992,034	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,992,885	0		50.00
51.00	05100	RECOVERY ROOM	0	744,582	0		51.00
53.00	05300	ANESTHESIOLOGY	0	1,278,056	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,901,756	0		54.00
56.00	05600	RADIOISOTOPE	0	1,978,644	0		56.00
57.00	05700	CT SCAN	0	7,276,450	0		57.00
58.00	05800	MRI	0	2,182,494	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,849,805	0		59.00
60.00	06000	LABORATORY	0	4,389,439	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	278,821	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,963,242	0		69.00
69.01	03160	CARDIOPULMONARY	0	108,472	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	38,420	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,879,849	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,491,153	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,158,467	0		73.00
74.00	07400	RENAL DIALYSIS	0	126,731	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	3,453,315	0		90.00
91.00	09100	EMERGENCY	0	7,665,587	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,995,296	0		92.00
200.00		Total (lines 50-199)	0	59,753,464	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.209967	5,992,885	0	0	1,258,308	50.00
51.00	05100	RECOVERY ROOM	0.147612	744,582	0	0	109,909	51.00
53.00	05300	ANESTHESIOLOGY	0.036458	1,278,056	0	0	46,595	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164539	3,901,756	0	0	641,991	54.00
56.00	05600	RADIOISOTOPE	0.095468	1,978,644	0	0	188,897	56.00
57.00	05700	CT SCAN	0.032010	7,276,450	0	0	232,919	57.00
58.00	05800	MRI	0.052651	2,182,494	0	0	114,910	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085986	1,849,805	0	0	159,057	59.00
60.00	06000	LABORATORY	0.105647	4,389,439	0	584	463,731	60.00
65.00	06500	RESPIRATORY THERAPY	0.086844	278,821	0	0	24,214	65.00
66.00	06600	PHYSICAL THERAPY	0.267462	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207748	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.318916	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059437	2,963,242	0	0	176,126	69.00
69.01	03160	CARDIOPULMONARY	0.771599	108,472	0	0	83,697	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277471	38,420	0	0	10,660	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.617968	1,879,849	0	13,085	1,161,687	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367921	2,491,153	0	11,780	916,548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100298	7,158,467	0	167,649	717,980	73.00
74.00	07400	RENAL DIALYSIS	0.195829	126,731	0	0	24,818	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.237421	3,453,315	0	0	819,890	90.00
91.00	09100	EMERGENCY	0.119017	7,665,587	0	0	912,335	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.223555	3,995,296	0	0	893,168	92.00
200.00		Subtotal (see instructions)		59,753,464	0	193,098	8,957,440	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		59,753,464	0	193,098	8,957,440	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	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
56.00	05600	RADIOISOTOPE	0	0		56.00
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	62		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,086		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,334		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,815		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	29,297		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	29,297		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140251 | Component CCN: 145548 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140251 | Component CCN: 145548 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,011,407	0.000000	0.000000	92,366	50.00
51.00	05100	RECOVERY ROOM	0	5,199,137	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	6,948,069	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,808,577	0.000000	0.000000	383,717	54.00
56.00	05600	RADIOISOTOPE	0	6,509,197	0.000000	0.000000	12,119	56.00
57.00	05700	CT SCAN	0	42,168,323	0.000000	0.000000	4,518	57.00
58.00	05800	MRI	0	9,011,454	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,972,079	0.000000	0.000000	2,008	59.00
60.00	06000	LABORATORY	0	76,536,671	0.000000	0.000000	3,058,437	60.00
65.00	06500	RESPIRATORY THERAPY	0	29,367,677	0.000000	0.000000	1,393,113	65.00
66.00	06600	PHYSICAL THERAPY	0	12,482,435	0.000000	0.000000	5,621,293	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,824,641	0.000000	0.000000	3,394,217	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,017,530	0.000000	0.000000	174,813	68.00
69.00	06900	ELECTROCARDIOLOGY	0	19,609,540	0.000000	0.000000	78,424	69.00
69.01	03160	CARDIOPULMONARY	0	637,840	0.000000	0.000000	59,237	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	300,691	0.000000	0.000000	1,796	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,645,736	0.000000	0.000000	1,442,748	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,868,059	0.000000	0.000000	556	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	96,829,730	0.000000	0.000000	6,425,948	73.00
74.00	07400	RENAL DIALYSIS	0	2,518,206	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,860,623	0.000000	0.000000	2,372	90.00
91.00	09100	EMERGENCY	0	69,669,218	0.000000	0.000000	4,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	11,125,801	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	505,922,641			22,152,144	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140251 | Component CCN: 145548 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140251 | Component CCN: 145548 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.209967	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.147612	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.036458	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164539	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.095468	0	0	0	0	56.00
57.00	05700	CT SCAN	0.032010	0	0	0	0	57.00
58.00	05800	MRI	0.052651	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085986	0	0	0	0	59.00
60.00	06000	LABORATORY	0.105647	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.086844	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.267462	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207748	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.318916	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059437	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.771599	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277471	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.617968	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367921	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100298	0	0	1,283	0	73.00
74.00	07400	RENAL DIALYSIS	0.195829	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.237421	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.119017	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.223555	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	1,283	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	1,283	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140251 | Component CCN: 145548 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
56.00	05600	RADIOISOTOPE	0	0		56.00
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
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
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	129		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	129		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	129		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	29,584	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,584	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)	26,334	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)	13,178	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)	22,640,713	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)	22,640,713	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)	22,640,713	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)	765.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	10,085,123	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)	10,085,123	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	8,369,485	6,222	1,345.14	3,034	4,081,155	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)	17,757,990	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	31,924,268	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,066,504	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,252,500	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,319,004	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	29,605,264	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)	3,250	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	765.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,487,225	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,934,390	22,640,713	0.085439	2,487,225	212,506	90.00
91.00	Nursing School cost	0	22,640,713	0.000000	2,487,225	0	91.00
92.00	Allied health cost	0	22,640,713	0.000000	2,487,225	0	92.00
93.00	All other Medical Education	0	22,640,713	0.000000	2,487,225	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140251 Component CCN: 145548	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/20/2015 6:15 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,886	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,886	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)	12,886	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)	10,653	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)	7,318,447	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)	7,318,447	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)	7,318,447	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: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 145548 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	7,318,447	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	567.94	71.00
72.00	Program routine service cost (line 9 x line 71)	6,050,265	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)	6,050,265	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)	6,050,265	83.00
84.00	Program inpatient ancillary services (see instructions)	4,380,726	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)	10,430,991	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: 140251 Component CCN: 145548	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/20/2015 6:15 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	29,584	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,584	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)	26,334	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)	3,819	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)	22,640,713	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)	22,640,713	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)	22,640,713	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)	765.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,922,681	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)	2,922,681	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	8,369,485	6,222	1,345.14	982	1,320,927	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,243,608	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)	3,250	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	765.30	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,487,225	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,934,390	22,640,713	0.085439	2,487,225	212,506	90.00
91.00	Nursing School cost	0	22,640,713	0.000000	2,487,225	0	91.00
92.00	Allied health cost	0	22,640,713	0.000000	2,487,225	0	92.00
93.00	All other Medical Education	0	22,640,713	0.000000	2,487,225	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		35,642,765		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		11,654,664		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209967	5,831,622	1,224,448	50.00
51.00	05100	RECOVERY ROOM	0.147612	1,172,642	173,096	51.00
53.00	05300	ANESTHESIOLOGY	0.036458	1,450,285	52,874	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164539	5,326,989	876,497	54.00
56.00	05600	RADIOISOTOPE	0.095468	1,027,533	98,097	56.00
57.00	05700	CT SCAN	0.032010	7,194,193	230,286	57.00
58.00	05800	MRI	0.052651	1,350,067	71,082	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085986	4,554,705	391,641	59.00
60.00	06000	LABORATORY	0.105647	21,787,193	2,301,752	60.00
65.00	06500	RESPIRATORY THERAPY	0.086844	9,360,212	812,878	65.00
66.00	06600	PHYSICAL THERAPY	0.267462	1,179,270	315,410	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207748	380,918	79,135	67.00
68.00	06800	SPEECH PATHOLOGY	0.318916	438,773	139,932	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059437	5,930,589	352,496	69.00
69.01	03160	CARDIOPULMONARY	0.771599	165,161	127,438	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277471	104,478	28,990	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.617968	7,287,294	4,503,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367921	3,057,867	1,125,053	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100298	30,977,480	3,106,979	73.00
74.00	07400	RENAL DIALYSIS	0.195829	1,409,569	276,034	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.237421	1,292,276	306,813	90.00
91.00	09100	EMERGENCY	0.119017	7,500,344	892,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.223555	1,212,574	271,077	92.00
200.00		Total (sum of lines 50-94 and 96-98)		119,992,034	17,757,990	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)		119,992,034		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 145548 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.209967	92,366	19,394	50.00
51.00	05100	RECOVERY ROOM	0.147612	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.036458	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.164539	383,717	63,136	54.00
56.00	05600	RADIOISOTOPE	0.095468	12,119	1,157	56.00
57.00	05700	CT SCAN	0.032010	4,518	145	57.00
58.00	05800	MRI	0.052651	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.085986	2,008	173	59.00
60.00	06000	LABORATORY	0.105647	3,058,437	323,115	60.00
65.00	06500	RESPIRATORY THERAPY	0.086844	1,393,113	120,984	65.00
66.00	06600	PHYSICAL THERAPY	0.267462	5,621,293	1,503,482	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207748	3,394,217	705,142	67.00
68.00	06800	SPEECH PATHOLOGY	0.318916	174,813	55,751	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059437	78,424	4,661	69.00
69.01	03160	CARDIOPULMONARY	0.771599	59,237	45,707	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277471	1,796	498	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.617968	1,442,748	891,572	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.367921	556	205	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.100298	6,425,948	644,510	73.00
74.00	07400	RENAL DIALYSIS	0.195829	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.237421	2,372	563	90.00
91.00	09100	EMERGENCY	0.119017	4,462	531	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.223555	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		22,152,144	4,380,726	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		22,152,144		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/20/2015 6:15 pm
	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)		19,632,053		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,473,227		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)		348,350		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		5,210,536		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		204.10		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		1.56		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.11		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).		1.50		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		2.95		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.57		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		2.57		12.00
13.00	Total allowable FTE count for the prior year.		3.11		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.		3.15		14.00
15.00	Sum of lines 12 through 14 divided by 3.		2.94		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		2.94		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.014405		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.014725		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.014405		21.00
22.00	IME payment adjustment (see instructions)		245,579		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)		-0.38		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)		245,579		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)		9.83		30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.95		31.00
32.00	Sum of lines 30 and 31		34.78		32.00
33.00	Allowable disproportionate share percentage (see instructions)		17.91		33.00
34.00	Disproportionate share adjustment (see instructions)		1,168,864		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,357,588	1,935,355	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,763,346	487,816	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,251,162		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		30,119,235		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)		30,119,235		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,271,984		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).		131,385		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 intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		32,522,604		59.00
60.00	Primary payer payments		7,098		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		32,515,506		61.00
62.00	Deductibles billed to program beneficiaries		2,508,544		62.00
63.00	Coinsurance billed to program beneficiaries		193,816		63.00
64.00	Allowable bad debts (see instructions)		916,772		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		595,902		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		689,902		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		30,409,048		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)		51,628		70.93
70.94	HRR adjustment amount (see instructions)		-153,714		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/20/2015 6:15 pm
	Title XVIII	Hospital	PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		30,306,962		71.00
71.01	Sequestration adjustment (see instructions)		606,139		71.01
72.00	Interim payments		29,009,350		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)		691,473		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		49,600		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/20/2015 6:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	29,297	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,957,440	2.00
3.00	PPS payments	8,577,091	3.00
4.00	Outlier payment (see instructions)	19,857	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)	29,297	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	193,098	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)	193,098	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	193,098	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	163,801	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	29,297	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	8,596,948	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)	1,911,202	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)	6,715,043	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	27,094	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)	6,742,137	30.00
31.00	Primary payer payments	41	31.00
32.00	Subtotal (line 30 minus line 31)	6,742,096	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)	765,643	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	497,668	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	634,394	36.00
37.00	Subtotal (see instructions)	7,239,764	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)	7,239,764	40.00
40.01	Sequestration adjustment (see instructions)	144,795	40.01
41.00	Interim payments	7,029,583	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	65,386	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140251 Component CCN: 145548	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/20/2015 6:15 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	129	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)	129	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,283	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)	1,283	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,283	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,154	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)	129	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)	129	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)	129	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	129	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)	129	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)	129	40.00
40.01	Sequestration adjustment (see instructions)	3	40.01
41.00	Interim payments	163	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-37	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		28,086,493		6,560,827	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		782,732		420,938	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	08/18/2014	149,800	08/18/2014	47,818	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	12/16/2014	9,675		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)		140,125		47,818	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		29,009,350		7,029,583	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		691,473		65,386	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		29,700,823		7,094,969	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: 140251 | Component CCN: 145548 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,259,397		163	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,259,397		163	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		37	6.02
7.00	Total Medicare program liability (see instructions)		5,259,397		126	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: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/20/2015 6:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	6,604	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	16,212	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3,273	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	32,556	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	612,699,249	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	15,117,963	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)	1,422,479	8.00
9.00	Sequestration adjustment amount (see instructions)	28,450	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,394,029	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,550,069	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)	-156,040	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140251 Component CCN: 145548	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VI Date/Time Prepared: 5/20/2015 6:15 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	5,612,568	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)	5,612,568	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	245,836	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	5,366,732	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	5,366,732	15.00
15.01	Sequestration adjustment (see instructions)	107,335	15.01
16.00	Interim payments	5,259,397	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)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/20/2015 6:15 pm
	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	4,243,608		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)	4,243,608	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)	4,243,608	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	4,243,608	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	4,243,608	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-4 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			1.56	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.13	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			1.25	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			2.68	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.57	6.00
7.00	Enter the lesser of line 5 or line 6			2.57	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.12	2.12	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.12	2.12	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	0.00	2.12		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.11		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.15		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	2.79		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	0.00	2.79		17.00
18.00	Per resident amount	97,213.96	97,213.96		18.00
19.00	Approved amount for resident costs	0	271,227	271,227	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)			271,227	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	16,212	3,273		26.00
27.00	Total Inpatient Days (see instructions)	32,556	32,556		27.00
28.00	Ratio of inpatient days to total inpatient days	0.497973	0.100534		28.00
29.00	Program direct GME amount	135,064	27,268		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		3,853		30.00
31.00	Net Program direct GME amount			158,479	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-4 | Date/Time Prepared: 5/20/2015 6:15 pm

Title XVIII | Hospital | PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	2,518,206	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)	43,587,101	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)	7,098	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	43,580,003	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	8,986,866	42.00
43.00	Primary payer payments (see instructions)	41	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	8,986,825	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	52,566,828	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.829040	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.170960	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	158,479	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	131,385	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	27,094	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/20/2015 6:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	725,540	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	101,666,645	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	453,811	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-79,477,836	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,114,000	0	0	0	9.00
10.00	Due from other funds	10,324,207	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	34,806,367	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	126,851,839	0	0	0	19.00
20.00	Accumulated depreciation	-126,851,839	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,806,367	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,080,426	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				42.00
43.00	Due to other funds	23,724,221	0	0	0	43.00
44.00	Other current liabilities	6,304,583	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	31,109,230	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	10,935,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	10,935,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	42,044,230	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-7,237,863				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-7,237,863	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,806,367	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/20/2015 6:15 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		34,206,642		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-9,825,490				2.00
3.00	Total (sum of line 1 and line 2)		24,381,152		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	RECONCILIATION	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,381,152		0		11.00
12.00	TRANSFERS	31,619,015		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		31,619,015		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-7,237,863		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	RECONCILIATION		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	TRANSFERS		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: 140251 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/20/2015 6:15 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	70,536,248		70,536,248	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	11,921,033		11,921,033	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)	82,457,281		82,457,281	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	24,319,327		24,319,327	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	24,319,327		24,319,327	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	106,776,608		106,776,608	17.00
18.00	Ancillary services	279,363,289	226,559,350	505,922,639	18.00
19.00	Outpatient services	0	0	0	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 PATIENT REVENUES	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	386,139,897	226,559,350	612,699,247	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		112,009,236		29.00
30.00	RECONCILATION	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		112,009,236		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/20/2015 6:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	612,699,247	1.00
2.00	Less contractual allowances and discounts on patients' accounts	512,983,313	2.00
3.00	Net patient revenues (line 1 minus line 2)	99,715,934	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	112,009,236	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,293,302	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	3,727	6.00
7.00	Income from investments	2,167,973	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 SERVICES	0	24.00
24.01	NET ASSETS RELASED FROM RESTRICTIONS	296,119	24.01
24.02	RECONCILIATION	-7	24.02
25.00	Total other income (sum of lines 6-24)	2,467,812	25.00
26.00	Total (line 5 plus line 25)	-9,825,490	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-9,825,490	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140251	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/20/2015 6:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	2,086,379	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	14,105	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)	89.19	3.00
4.00	Number of interns & residents (see instructions)	2.94	4.00
5.00	Indirect medical education percentage (see instructions)	0.93	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	19,403	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	9.83	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	24.95	8.00
9.00	Sum of lines 7 and 8	34.78	9.00
10.00	Allowable disproportionate share percentage (see instructions)	7.29	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	152,097	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	2,271,984	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