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: 140275	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/20/2014 3:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/20/2014 Time: 3:22 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 GENESIS MEDICAL CENTER - SILVIS (140275) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

VICE PRESIDENT, FINANCE/CFO
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	103,531	37,726	812,421	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	-1	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
200.00	Total	0	103,530	37,726	812,421	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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2014 3:21 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 HOSPITAL ROAD	PO Box:			1.00
2.00	City: SILVIS	State: IL	Zip Code: 61282-	County: ROCK ISLAND	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	GENESIS MEDICAL CENTER - SILVIS	140275	19340	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	ILLINI RESTORATIVE CARE CENTER	145703	19340		09/03/1991	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)	07/01/2013	06/30/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,725	455	0	79	78	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2014 3:21 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

		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 Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2014 3:21 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)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2014 3:21 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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2014 3:21 pm

		V	XIX	
		1.00	2.00	
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 Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	266,420	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2014 3:21 pm

		1.00	2.00	
	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	H55790	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: GENESIS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 05001	141.00
142.00	Street: 1227 E. RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	143.00

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2013	06/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2014 3:21 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	11/04/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/20/2014 3:21 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARTIN	ORWITZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175	ORWITZM@GENESISHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/20/2014 3:21 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)	11/04/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2014 3:21 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	142	51,830	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)		142	51,830	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		149	54,385	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	83	30,295		0	19.00
20.00	NURSING FACILITY	45.00	37	13,505		0	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)		269				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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2014 3:21 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)	5,238	1,604	10,685			1.00
2.00	HMO and other (see instructions)	1,302	871				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)	5,238	1,604	10,685			7.00
8.00	INTENSIVE CARE UNIT	537	70	1,059			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		792	1,363			13.00
14.00	Total (see instructions)	5,775	2,466	13,107	0.00	425.18	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	8,198	5,050	27,471	0.00	79.86	19.00
20.00	NURSING FACILITY		0	10,693	0.00	11.84	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	516.88	27.00
28.00	Observation Bed Days		25	1,669			28.00
29.00	Ambulance Trips	3,267					29.00
30.00	Employee discount days (see instruction)			173			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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/20/2014 3:21 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,643	1,049	4,492	1.00
2.00	HMO and other (see instructions)			386	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,643	1,049	4,492	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	0.00					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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part II Date/Time Prepared: 11/20/2014 3:21 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	28,068,077	0	28,068,077	1,006,961.00	27.87	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	2,958,203	148,128	3,106,331	167,418.00	18.55	9.00
10.00	Excluded area salaries (see instructions)		2,879,808	930,860	3,810,668	225,149.00	16.93	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		685,898	0	685,898	9,252.00	74.14	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		106,858	0	106,858	1,297.00	82.39	13.00
14.00	Home office salaries & wage-related costs		8,647,676	0	8,647,676	180,278.00	47.97	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)		5,316,516	0	5,316,516			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,852,506	0	1,852,506			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	13,726	0	13,726	962.00	14.27	26.00
27.00	Administrative & General	5.00	895,151	0	895,151	20,787.00	43.06	27.00
28.00	Administrative & General under contract (see inst.)		128,665	0	128,665	1,104.00	116.54	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	932,278	0	932,278	45,676.00	20.41	30.00
31.00	Laundry & Linen Service	8.00	48,940	-18,226	30,714	2,431.00	12.63	31.00
32.00	Housekeeping	9.00	506,286	-15,330	490,956	35,040.00	14.01	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,202,809	-1,045,432	157,377	9,381.00	16.78	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	583,521	0	583,521	18,064.00	32.30	38.00
39.00	Central Services and Supply	14.00	95,330	0	95,330	6,398.00	14.90	39.00
40.00	Pharmacy	15.00	1,495,929	0	1,495,929	33,834.00	44.21	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part II Date/Time Prepared: 11/20/2014 3:21 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	0	0	0	0.00	0.00	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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part III Date/Time Prepared: 11/20/2014 3:21 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)		28,196,742	0	28,196,742	1,008,065.00	27.97	1.00
2.00	Excluded area salaries (see instructions)		5,838,011	1,078,988	6,916,999	392,567.00	17.62	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,358,731	-1,078,988	21,279,743	615,498.00	34.57	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,440,432	0	9,440,432	190,827.00	49.47	4.00
5.00	Subtotal wage-related costs (see inst.)		5,316,516	0	5,316,516	0.00	24.98	5.00
6.00	Total (sum of lines 3 thru 5)		37,115,679	-1,078,988	36,036,691	806,325.00	44.69	6.00
7.00	Total overhead cost (see instructions)		5,902,635	-1,078,988	4,823,647	173,677.00	27.77	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part IV Date/Time Prepared: 11/20/2014 3:21 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	709,218	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,892,628	8.00
9.00	Prescription Drug Plan	487,918	9.00
10.00	Dental, Hearing and Vision Plan	207,015	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	41,182	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)	122,906	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	520,247	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,053,912	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	49,919	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	289	22.00
23.00	Tuition Reimbursement	83,788	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,169,022	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part V | Date/Time Prepared: 11/20/2014 3:21 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	685,898	7,169,022	1.00
2.00	Hospital	685,898	5,316,516	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	1,852,506	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-7 | Date/Time Prepared: 11/20/2014 3:21 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.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	534	0	534	12.00
13.00		RUB	1,409	0	1,409	13.00
14.00		RUA	1,371	0	1,371	14.00
15.00		RVC	1,127	0	1,127	15.00
16.00		RVB	1,437	0	1,437	16.00
17.00		RVA	1,389	0	1,389	17.00
18.00		RHC	159	0	159	18.00
19.00		RHB	225	0	225	19.00
20.00		RHA	162	0	162	20.00
21.00		RMC	73	0	73	21.00
22.00		RMB	15	0	15	22.00
23.00		RMA	36	0	36	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	8	0	8	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	16	0	16	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	8	0	8	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	7	0	7	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	1	0	1	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	8	0	8	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	9	0	9	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	52	0	52	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	13	0	13	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	96	0	96	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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-7 | Date/Time Prepared: 11/20/2014 3:21 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	3	0	3	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	23	0	23	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	7	0	7	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	3	0	3	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		8,198	0	8,198	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).	19340	19340	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	8,019,470			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 11/20/2014 3:21 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)	0.338731	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,393,766	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	34,235,483	6.00
7.00	Medicaid cost (line 1 times line 6)	11,596,619	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,202,853	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)	1,202,853	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	6,103,185	0	6,103,185	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,067,338	0	2,067,338	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,067,338	0	2,067,338	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	7,377,444	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	289,870	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	7,087,574	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,400,781	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,468,119	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,670,972	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/20/2014 3:21 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	NEW CAP REL COSTS-BLDG & FIXT		1,577,874	1,577,874	-141,356	1,436,518	1.00
1.01	00101	NEW CAP RELATED IRC		571,398	571,398	0	571,398	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,315,526	2,315,526	0	2,315,526	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,726	4,183,668	4,197,394	0	4,197,394	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	895,151	22,361,414	23,256,565	0	23,256,565	5.00
7.00	00700	OPERATION OF PLANT	932,278	2,213,291	3,145,569	0	3,145,569	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	48,940	50,469	99,409	-37,022	62,387	8.00
9.00	00900	HOUSEKEEPING	506,286	157,637	663,923	-20,103	643,820	9.00
10.00	01000	DIETARY	1,202,809	2,133,883	3,336,692	-2,900,114	436,578	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	583,521	66,585	650,106	0	650,106	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95,330	234,686	330,016	0	330,016	14.00
15.00	01500	PHARMACY	1,495,929	373,994	1,869,923	0	1,869,923	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,210,353	1,694,898	6,905,251	-396,152	6,509,099	30.00
31.00	03100	INTENSIVE CARE UNIT	790,815	175,056	965,871	0	965,871	31.00
43.00	04300	NURSERY	0	0	0	396,152	396,152	43.00
44.00	04400	SKILLED NURSING FACILITY	2,958,203	869,130	3,827,333	349,337	4,176,670	44.00
45.00	04500	NURSING FACILITY	346,416	31,418	377,834	499,082	876,916	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,507,381	1,026,532	2,533,913	0	2,533,913	50.00
53.00	05300	ANESTHESIOLOGY	11	248,012	248,023	0	248,023	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	894,732	129,716	1,024,448	0	1,024,448	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	75,252	176,384	251,636	0	251,636	55.00
57.00	05700	CT SCAN	183,531	104,692	288,223	0	288,223	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	86,850	94,014	180,864	0	180,864	58.00
59.00	05900	CARDIAC CATHETERIZATION	346,823	583,645	930,468	0	930,468	59.00
60.00	06000	LABORATORY	1,992,802	3,434,704	5,427,506	0	5,427,506	60.00
65.00	06500	RESPIRATORY THERAPY	1,031,775	321,498	1,353,273	0	1,353,273	65.00
66.00	06600	PHYSICAL THERAPY	2,032,736	421,016	2,453,752	0	2,453,752	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,709,577	4,709,577	-3,103,123	1,606,454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,103,123	3,103,123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,051,633	3,051,633	0	3,051,633	73.00
76.00	03020	CARDIAC REHAB	396,057	227,527	623,584	0	623,584	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	86,734	9,615	96,349	0	96,349	90.00
90.01	09001	WOUND CENTER	57,425	186,250	243,675	0	243,675	90.01
91.00	09100	EMERGENCY	1,762,819	3,720,274	5,483,093	0	5,483,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,169,505	1,026,641	3,196,146	3,420	3,199,566	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,704,190	58,482,657	86,186,847	-2,246,756	83,940,091	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,971	39,971	9,206	49,177	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,793	415,011	442,804	3,834	446,638	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	145,413	145,413	192.01
194.00	07950	CROSSTOWN SQUARE	173,048	284,230	457,278	320,893	778,171	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	1,091,527	1,091,527	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	675,883	675,883	194.03
194.04	07951	OUTREACH	163,046	25,652	188,698	0	188,698	194.04
200.00		TOTAL (SUM OF LINES 118-199)	28,068,077	59,247,521	87,315,598	0	87,315,598	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,624,109	3,060,627		1.00
1.01	00101	NEW CAP RELATED IRC	-180,579	390,819		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,315,526		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0	0		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,241,077	2,956,317		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,849,599	13,406,966		5.00
7.00	00700	OPERATION OF PLANT	-39,065	3,106,504		7.00
7.01	00701	OPERATION OF PLANT IRC	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	62,387		8.00
9.00	00900	HOUSEKEEPING	-87,719	556,101		9.00
10.00	01000	DIETARY	0	436,578		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	650,106		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	553,535	883,551		14.00
15.00	01500	PHARMACY	-36,675	1,833,248		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,023,369	1,023,369		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-693,214	5,815,885		30.00
31.00	03100	INTENSIVE CARE UNIT	-11,538	954,333		31.00
43.00	04300	NURSERY	0	396,152		43.00
44.00	04400	SKILLED NURSING FACILITY	-134,402	4,042,268		44.00
45.00	04500	NURSING FACILITY	0	876,916		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-92,864	2,441,049		50.00
53.00	05300	ANESTHESIOLOGY	-203,959	44,064		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,024,448		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	251,636		55.00
57.00	05700	CT SCAN	0	288,223		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	180,864		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	930,468		59.00
60.00	06000	LABORATORY	-126,242	5,301,264		60.00
65.00	06500	RESPIRATORY THERAPY	-53,175	1,300,098		65.00
66.00	06600	PHYSICAL THERAPY	-89,360	2,364,392		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-135	1,606,319		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,103,123		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,051,633		73.00
76.00	03020	CARDIAC REHAB	-3,260	620,324		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-870	95,479		90.00
90.01	09001	WOUND CENTER	-33,997	209,678		90.01
91.00	09100	EMERGENCY	-3,345,043	2,138,050		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,124,403	2,075,163		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,146,163	69,793,928		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49,177		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	446,638		192.00
192.01	19201	NONREIMBURSABLE	0	145,413		192.01
194.00	07950	CROSSTOWN SQUARE	-91,919	686,252		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	1,091,527		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	675,883		194.03
194.04	07951	OUTREACH	0	188,698		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-14,238,082	73,077,516		200.00

RECLASSIFICATIONS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/20/2014 3:21 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - POB DEPRECIATION					
1.00	NONREIMBURSABLE	192.01	0	141,356		1.00
	TOTALS		0	141,356		
	B - NURSING HOME OVERHEAD COSTS					
1.00	SKILLED NURSING FACILITY	44.00	42,992	26,526		1.00
	TOTALS		42,992	26,526		
	C - NURSERY COSTS					
1.00	NURSERY	43.00	328,488	67,664		1.00
	TOTALS		328,488	67,664		
	D - CHARGEABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,103,123		1.00
	TOTALS		0	3,103,123		
	E - DIETARY COST AND EMPLOYEE MEALS					
1.00	SKILLED NURSING FACILITY	44.00	89,201	158,250		1.00
2.00	NURSING FACILITY	45.00	203,867	361,676		2.00
3.00	CROSSTOWN SQUARE	194.00	115,249	204,461		3.00
4.00	NONALLOWABLE PHYSICIAN	194.02	393,473	698,054		4.00
5.00	NONALLOWABLE GUEST MEALS	194.03	243,642	432,241		5.00
	TOTALS		1,045,432	1,854,682		
	F - RECLASS HOUSEKEEPING COST					
1.00	AMBULANCE SERVICES	95.00	2,608	812		1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	7,020	2,186		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	2,608	812		3.00
4.00	NONREIMBURSABLE	192.01	3,094	963		4.00
	TOTALS		15,330	4,773		
	G - RECLASS LAUNDRY COST					
1.00	SKILLED NURSING FACILITY	44.00	15,935	16,433		1.00
2.00	NURSING FACILITY	45.00	1,505	1,552		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	204	210		3.00
4.00	CROSSTOWN SQUARE	194.00	582	601		4.00
	TOTALS		18,226	18,796		
500.00	Grand Total: Increases		1,450,468	5,216,920		500.00

RECLASSIFICATIONS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/20/2014 3:21 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - POB DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	141,356	9		1.00
	TOTALS		0	141,356			
	B - NURSING HOME OVERHEAD COSTS						
1.00	NURSING FACILITY	45.00	42,992	26,526	0		1.00
	TOTALS		42,992	26,526			
	C - NURSERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	328,488	67,664	0		1.00
	TOTALS		328,488	67,664			
	D - CHARGEABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,103,123	0		1.00
	TOTALS		0	3,103,123			
	E - DIETARY COST AND EMPLOYEE MEALS						
1.00	DIETARY	10.00	1,045,432	1,854,682	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		1,045,432	1,854,682			
	F - RECLASS HOUSEKEEPING COST						
1.00	HOUSEKEEPING	9.00	15,330	4,773	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		15,330	4,773			
	G - RECLASS LAUNDRY COST						
1.00	LAUNDRY & LINEN SERVICE	8.00	18,226	18,796	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		18,226	18,796			
500.00	Grand Total: Decreases		1,450,468	5,216,920			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2014 3:21 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,374,122	0	0	0	0	1.00
2.00	Land Improvements	1,836,222	0	0	0	0	2.00
3.00	Buildings and Fixtures	56,588,212	490,466	0	490,466	0	3.00
4.00	Building Improvements	16,771	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	43,348,687	1,651,398	0	1,651,398	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	104,164,014	2,141,864	0	2,141,864	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	104,164,014	2,141,864	0	2,141,864	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,374,122	0	1.00
2.00	Land Improvements	1,836,222	0	2.00
3.00	Buildings and Fixtures	57,078,678	0	3.00
4.00	Building Improvements	16,771	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	45,000,085	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	106,305,878	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	106,305,878	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 11/20/2014 3:21 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	NEW CAP REL COSTS-BLDG & FIXT	1,577,874	0	0	0	0	1.00
1.01	NEW CAP RELATED IRC	571,398	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,315,526	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	4,464,798	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,577,874		1.00
1.01	NEW CAP RELATED IRC	0	571,398		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,315,526		2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0		2.01
3.00	Total (sum of lines 1-2)	0	4,464,798		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/20/2014 3:21 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	NEW CAP REL COSTS-BLDG & FIXT	58,931,670	0	58,931,670	0.567023	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	45,000,085	0	45,000,085	0.432977	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	103,931,755	0	103,931,755	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,060,693	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	571,398	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,315,526	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	5,947,617	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	NEW CAP REL COSTS-BLDG & FIXT	-66	0	0	0	3,060,627	1.00
1.01	NEW CAP RELATED IRC	-180,579	0	0	0	390,819	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,315,526	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	-180,645	0	0	0	5,766,972	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/20/2014 3:21 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP RELATED IRC (chapter 2)		0	NEW CAP RELATED IRC	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP IRC (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,518,149			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	-762,290			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP RELATED IRC		0	NEW CAP RELATED IRC	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP IRC		0	CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/20/2014 3:21 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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	AMBULANCE - CPE REVENUE	B	-32,501	AMBULANCE SERVICES	95.00	0	33.00
34.00	AMBULANCE - MISCELLANEOUS REVENUE	B	-641,336	AMBULANCE SERVICES	95.00	0	34.00
35.00	AMBULANCE OUTREACH - MISCELLANEOUS R	B	-434,533	AMBULANCE SERVICES	95.00	0	35.00
35.03	PEDIATRICS - MISCELLANEOUS REVENUE	B	-155	ADULTS & PEDIATRICS	30.00	0	35.03
35.05	PHYSICAL THERAPY - MISCELLANEOUS REV	B	-2,817	PHYSICAL THERAPY	66.00	0	35.05
35.07	P.T. CLINIC - KING PLAZA MOLIN - INT	B	-82,155	PHYSICAL THERAPY	66.00	0	35.07
35.08	P.T. CLINIC - KING PLAZA MOLIN - MIS	B	-245	PHYSICAL THERAPY	66.00	0	35.08
35.11	TRAUMA - MISCELLANEOUS REVENUE	B	-52,471	EMERGENCY	91.00	0	35.11
35.13	CARDIAC REHAB - MISCELLANEOUS REVENU	B	-3,260	CARDIAC REHAB	76.00	0	35.13
35.14	DIABETES CARE CENTER - MISCELLANEOUS	B	-120	CLINIC	90.00	0	35.14
35.15	OR/RECOVERY - VENDOR REBATES	B	-14	OPERATING ROOM	50.00	9	35.15
36.00	CANCER CENTER - MISCELLANEOUS REVENU	B	-335	ADMINISTRATIVE & GENERAL	5.00	9	36.00
36.01	DISTRIBUTION - INVENTORY RECOVERIES	B	-135	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	36.01
36.03	PHARMACY - INTERCOMPANY REVENUE	B	-36,675	PHARMACY	15.00	0	36.03
36.07	ADMINISTRATION - RENTAL INCOME -3RD	B	-34,026	ADMINISTRATIVE & GENERAL	5.00	0	36.07
36.08	ADMINISTRATION - DISCOUNTS EARNED	B	-9,193	ADMINISTRATIVE & GENERAL	5.00	0	36.08
36.09	INFORMATION TECHNOLOGY - MISCELLANEO	B	-7,986	ADMINISTRATIVE & GENERAL	5.00	9	36.09
36.10	MEDICAL STAFF - ILLINI - MISCELLANEO	B	-37,005	ADMINISTRATIVE & GENERAL	5.00	0	36.10
36.11	ENVIRONMENTAL SERVICES - INTERCOMPAN	B	-87,719	HOUSEKEEPING	9.00	0	36.11
36.13	BIRTH ASSOCIATES - MISCELLANEOUS REV	B	-2,790	ADULTS & PEDIATRICS	30.00	0	36.13
36.14	GROUNDS - INTERCOMPANY REVENUE	B	-3,677	OPERATION OF PLANT	7.00	0	36.14
36.15	MAINTENANCE - INTERCOMPANY REVENUE	B	-35,116	OPERATION OF PLANT	7.00	0	36.15
36.16	MAINTENANCE - MISCELLANEOUS REVENUE	B	-272	OPERATION OF PLANT	7.00	0	36.16
36.18	GRANTS 2 - MISCELLANEOUS REVENUE	B	-29,573	ADMINISTRATIVE & GENERAL	5.00	0	36.18
36.20	SWITCHBOARD - MISCELLANEOUS REVENUE	B	-755	ADMINISTRATIVE & GENERAL	5.00	0	36.20
36.21	PHYSICIAN SUPPORT SVCS - RENT 3RD PA	B	-178,156	ADMINISTRATIVE & GENERAL	5.00	10	36.21
37.00	PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-1,320	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	VOLUNTEER SERVICES - MISC REVENUE	B	-300	ADMINISTRATIVE & GENERAL	5.00	0	37.01
37.06	INTEREST - INTEREST EXPENSE - 2010 B	A	-247,651	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	37.06
37.07	INTEREST - INTEREST EXP CAP INT OFF	A	247,585	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	37.07
37.09	INTEREST- IRC - INTEREST EXPENSE - R	A	-180,579	NEW CAP RELATED IRC	1.01	11	37.09
37.10	INTEREST - CS - INTEREST EXPENSE - R	A	-66,790	CROSSTOWN SQUARE	194.00	0	37.10

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/20/2014 3:21 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	
37.11	NURSING FLOOR - IRC MEDICARE - CONTR	A	-54,367	SKILLED NURSING FACILITY	44.00	0	37.11
37.12	ENVIRONMENTAL SVCS - IRC - CONTRACT	A	-63,319	SKILLED NURSING FACILITY	44.00	0	37.12
37.14	ENVIRONMENTAL SVC - CS - CONTRACT FE	A	-1,432	CROSSTOWN SQUARE	194.00	0	37.14
38.00			0		0.00	0	38.00
39.00			0		0.00	0	39.00
39.01	SECURITY - IRC - CONTRACT FEES- ILLI	A	-16,716	SKILLED NURSING FACILITY	44.00	0	39.01
39.02	SECURITY - CS - CONTRACT FEES- ILLIN	A	-7,836	CROSSTOWN SQUARE	194.00	0	39.02
39.03	ADMINISTRATION - PHYSICIAN PRACTICE	A	-2,268,708	ADMINISTRATIVE & GENERAL	5.00	0	39.03
39.04			0		0.00	0	39.04
40.00	PHYSICIAN SUPPORT SVCS - RENTAL FACI	A	-196,086	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN SUPPORT SVCS - RENTAL EQUI	A	-741	ADMINISTRATIVE & GENERAL	5.00	0	41.00
41.01	PHYSICIAN SUPPORT SVCS - M&R INHOUSE	A	-194	ADMINISTRATIVE & GENERAL	5.00	0	41.01
42.00	PHYSICIAN SUPPORT SVCS - TELEPHONE -	A	-65	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	ALCOHOL	A	-390	ADMINISTRATIVE & GENERAL	5.00	0	43.00
43.01	AMBULANCE - ADVERTISING & PROMOTIONS	A	-1,293	AMBULANCE SERVICES	95.00	0	43.01
43.02	LABORATORY - ADVERTISING & PROMOTION	A	-840	LABORATORY	60.00	0	43.02
43.03	PHYSICAL THERAPY - ADVERTISING & PRO	A	-2,074	PHYSICAL THERAPY	66.00	0	43.03
43.04	P.T. CLINIC - KING PLAZA MOLIN - ADV	A	-2,069	PHYSICAL THERAPY	66.00	0	43.04
43.06	WOUND CENTER - ADVERTISING & PROMOTI	A	-1,103	WOUND CENTER	90.01	0	43.06
43.07	ADMINISTRATION - ADVERTISING & PROMO	A	-174	ADMINISTRATIVE & GENERAL	5.00	0	43.07
43.08	CORPORATE COMMUNICATIONS - ADVERTISI	A	75	ADMINISTRATIVE & GENERAL	5.00	0	43.08
43.09	CORP COMMUNICATION - CS - ADVERTISIN	A	-15,861	CROSSTOWN SQUARE	194.00	0	43.09
43.10	ADMINISTRATION - PROVIDER TAX ASSESS	A	-2,969,653	ADMINISTRATIVE & GENERAL	5.00	0	43.10
43.11	NURSING ADMIN - IRC - PROVIDER TAX A	A	-100,920	ADMINISTRATIVE & GENERAL	5.00	0	43.11
43.12	ADMINISTRATOR - IRC - PROVIDER TAX A	A	-44,961	ADMINISTRATIVE & GENERAL	5.00	0	43.12
43.13	SELF INSURANCE	A	-1,241,077	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.13
43.14	LOBBYING	A	-5,764	ADMINISTRATIVE & GENERAL	5.00	0	43.14
43.15			0		0.00	0	43.15
45.00			0		0.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03			0		0.00	0	45.03
45.04			0		0.00	0	45.04
45.05			0		0.00	0	45.05
45.06			0		0.00	0	45.06
45.07			0		0.00	0	45.07
45.08			0		0.00	0	45.08
45.09			0		0.00	0	45.09
45.10			0		0.00	0	45.10
45.11			0		0.00	0	45.11
45.12			0		0.00	0	45.12
45.13			0		0.00	0	45.13
45.14			0		0.00	0	45.14
45.15			0		0.00	0	45.15
45.16			0		0.00	0	45.16
45.17			0		0.00	0	45.17
45.18			0		0.00	0	45.18
45.19			0		0.00	0	45.19
45.20			0		0.00	0	45.20

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/20/2014 3:21 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	
45.21			0		0.00	0	45.21
45.22			0		0.00	0	45.22
45.23			0		0.00	0	45.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,238,082				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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 11/20/2014 3:21 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	GHS HOME OFFICE COSTS	10,508,123	14,471,492	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	GHS HOME OFFICE COSTS	1,624,175	0	2.00
3.00	0.00			0	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	GHS HOME OFFICE COSTS	553,535	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	GHS HOME OFFICE COSTS	1,023,369	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00		GHS HOME OFFICE COSTS	0	0	4.04
5.00	0		0	13,709,202	14,471,492	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	C		0.00	GENESIS HEALTH SYSTEM	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140275	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/20/2014 3:21 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	-3,963,369	0		1.00
2.00	1,624,175	9		2.00
3.00	0	0		3.00
4.00	553,535	0		4.00
4.01	1,023,369	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	-762,290			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2014 3:21 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	60.00	LABORATORY	125,402	125,402	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	53,175	53,175	0	0	0	2.00
3.00	91.00	EMERGENCY	3,292,572	3,292,572	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	690,269	690,269	0	0	0	4.00
5.00	50.00	OPERATING ROOM	92,850	92,850	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	11,538	11,538	0	0	0	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	106,858	0	106,858	171,400	2,080	7.00
8.00	90.01	WOUND CENTER	32,894	32,894	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	203,959	203,959	0	0	0	9.00
10.00	90.00	CLINIC	750	750	0	0	0	10.00
11.00	95.00	AMBULANCE SERVICES	14,740	14,740	0	0	0	11.00
200.00			4,625,007	4,518,149	106,858		2,080	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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	171,400	8,570	0	0	0	7.00
8.00	90.01	WOUND CENTER	0	0	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	0	0	10.00
11.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	11.00
200.00			171,400	8,570	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	60.00	LABORATORY	0	0	0	125,402		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	53,175		2.00
3.00	91.00	EMERGENCY	0	0	0	3,292,572		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	690,269		4.00
5.00	50.00	OPERATING ROOM	0	0	0	92,850		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	11,538		6.00
7.00	5.00	ADMINISTRATIVE & GENERAL	0	171,400	0	0		7.00
8.00	90.01	WOUND CENTER	0	0	0	32,894		8.00
9.00	53.00	ANESTHESIOLOGY	0	0	0	203,959		9.00
10.00	90.00	CLINIC	0	0	0	750		10.00
11.00	95.00	AMBULANCE SERVICES	0	0	0	14,740		11.00
200.00			0	171,400	0	4,518,149		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,060,627	3,060,627				1.00
1.01	00101	NEW CAP RELATED IRC	390,819	0	390,819			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,315,526			2,315,526		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0			0	0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,956,317	1,502	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,406,966	144,210	0	99,451	0	5.00
7.00	00700	OPERATION OF PLANT	3,106,504	2,501,274	0	84,892	0	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	16,723	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	62,387	6,423	1,349	0	0	8.00
9.00	00900	HOUSEKEEPING	556,101	2,930	2,952	6,438	0	9.00
10.00	01000	DIETARY	436,578	14,169	0	6,371	0	10.00
11.00	01100	CAFETERIA	0	7,866	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	650,106	2,093	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	883,551	17,944	0	86,962	0	14.00
15.00	01500	PHARMACY	1,833,248	12,449	0	120,782	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,023,369	7,384	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,962	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,815,885	115,405	0	233,334	0	30.00
31.00	03100	INTENSIVE CARE UNIT	954,333	10,034	0	13,614	0	31.00
43.00	04300	NURSERY	396,152	5,819	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,042,268	0	223,138	0	0	44.00
45.00	04500	NURSING FACILITY	876,916	0	107,501	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,441,049	43,215	0	257,774	0	50.00
53.00	05300	ANESTHESIOLOGY	44,064	0	0	67,544	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,024,448	23,766	0	305,003	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	251,636	0	0	35,429	0	55.00
57.00	05700	CT SCAN	288,223	0	0	80,942	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	180,864	488	0	3,231	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	930,468	6,461	0	262,483	0	59.00
60.00	06000	LABORATORY	5,301,264	40,202	0	168,923	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,300,098	7,545	0	130,782	0	65.00
66.00	06600	PHYSICAL THERAPY	2,364,392	9,085	30,113	30,756	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,606,319	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,103,123	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,051,633	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	620,324	23,342	0	13,860	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	95,479	0	0	1,278	0	90.00
90.01	09001	WOUND CENTER	209,678	5,079	0	3,816	0	90.01
91.00	09100	EMERGENCY	2,138,050	23,707	0	69,839	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,075,163	19,052	0	231,223	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,793,928	3,054,406	381,776	2,314,727	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,177	4,279	2,639	630	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	446,638	1,942	0	72	0	192.00
192.01	19201	NONREIMBURSABLE	145,413	0	6,404	97	0	192.01
194.00	07950	CROSSTOWN SQUARE	686,252	0	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	1,091,527	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	675,883	0	0	0	0	194.03
194.04	07951	OUTREACH	188,698	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	73,077,516	3,060,627	390,819	2,315,526	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,957,819					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	94,378	13,745,005	13,745,005			5.00
7.00	00700	OPERATION OF PLANT	98,292	5,790,962	1,341,540	7,132,502		7.00
7.01	00701	OPERATION OF PLANT IRC	0	16,723	3,874	0	20,597	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,238	73,397	17,003	110,754	74	8.00
9.00	00900	HOUSEKEEPING	51,763	620,184	143,672	50,519	163	9.00
10.00	01000	DIETARY	16,593	473,711	109,740	244,316	0	10.00
11.00	01100	CAFETERIA	0	7,866	1,822	135,644	0	11.00
13.00	01300	NURSING ADMINISTRATION	61,522	713,721	165,341	36,085	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,051	998,508	231,315	309,409	0	14.00
15.00	01500	PHARMACY	157,719	2,124,198	492,094	214,662	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,030,753	238,785	127,317	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,962	686	51,075	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	514,697	6,679,321	1,547,318	1,989,968	0	30.00
31.00	03100	INTENSIVE CARE UNIT	83,377	1,061,358	245,875	173,025	0	31.00
43.00	04300	NURSERY	34,633	436,604	101,144	100,345	0	43.00
44.00	04400	SKILLED NURSING FACILITY	340,343	4,605,749	1,066,972	0	12,285	44.00
45.00	04500	NURSING FACILITY	40,807	1,025,224	237,504	0	5,919	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	158,926	2,900,964	672,040	745,163	0	50.00
53.00	05300	ANESTHESIOLOGY	1	111,609	25,855	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,333	1,447,550	335,341	409,800	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,934	294,999	68,340	0	0	55.00
57.00	05700	CT SCAN	19,350	388,515	90,004	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,157	193,740	44,882	8,420	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	36,566	1,235,978	286,328	111,402	0	59.00
60.00	06000	LABORATORY	210,105	5,720,494	1,325,215	693,209	0	60.00
65.00	06500	RESPIRATORY THERAPY	108,782	1,547,207	358,428	130,092	0	65.00
66.00	06600	PHYSICAL THERAPY	214,315	2,648,661	613,591	156,647	1,658	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,606,319	372,121	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,103,123	718,873	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,051,633	706,944	0	0	73.00
76.00	03020	CARDIAC REHAB	41,757	699,283	161,997	402,491	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,145	105,902	24,533	0	0	90.00
90.01	09001	WOUND CENTER	6,054	224,627	52,037	87,576	0	90.01
91.00	09100	EMERGENCY	185,858	2,417,454	560,030	408,782	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	229,010	2,554,448	591,766	328,516	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,838,706	69,658,752	12,953,010	7,025,217	20,099	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	740	57,465	13,312	73,790	145	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,227	451,879	104,683	33,495	0	192.00
192.01	19201	NONREIMBURSABLE	326	152,240	35,268	0	353	192.01
194.00	07950	CROSSTOWN SQUARE	30,457	716,709	166,034	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	41,485	1,133,012	262,475	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	25,688	701,571	162,527	0	0	194.03
194.04	07951	OUTREACH	17,190	205,888	47,696	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,957,819	73,077,516	13,745,005	7,132,502	20,597	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	201,228					8.00
9.00	00900	HOUSEKEEPING	0	814,538				9.00
10.00	01000	DIETARY	0	30,601	858,368			10.00
11.00	01100	CAFETERIA	0	16,990	636,156	798,478		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,520	0	13,485	933,152	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,622	38,754	0	4,897	0	14.00
15.00	01500	PHARMACY	0	9,173	0	25,565	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,947	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,397	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,545	249,249	210,569	147,566	397,420	30.00
31.00	03100	INTENSIVE CARE UNIT	3,203	21,672	11,643	20,977	52,557	31.00
43.00	04300	NURSERY	13,922	12,568	0	9,083	0	43.00
44.00	04400	SKILLED NURSING FACILITY	66,310	0	0	123,361	221,537	44.00
45.00	04500	NURSING FACILITY	6,264	0	0	18,289	39,959	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,359	93,333	0	39,715	74,158	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,117	51,328	0	25,411	54	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,483	4	55.00
57.00	05700	CT SCAN	3,974	0	0	4,464	25	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	922	1,055	0	1,838	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,836	13,953	0	7,600	10,506	59.00
60.00	06000	LABORATORY	37	51,282	0	64,770	4,765	60.00
65.00	06500	RESPIRATORY THERAPY	2,115	16,294	0	30,972	179	65.00
66.00	06600	PHYSICAL THERAPY	1,925	23,404	0	51,609	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	347	34,234	0	10,782	13,455	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,657	0	90.00
90.01	09001	WOUND CENTER	96	10,969	0	1,869	3,576	90.01
91.00	09100	EMERGENCY	26,785	51,201	0	46,712	101,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	41,147	0	84,758	2,390	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	200,379	794,071	858,368	737,863	922,033	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,294	0	386	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	849	4,195	0	1,576	10	192.00
192.01	19201	NONREIMBURSABLE	0	4,978	0	170	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	11,029	11,109	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	26,507	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	12,698	0	194.03
194.04	07951	OUTREACH	0	0	0	8,249	0	194.04
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)	201,228	814,538	858,368	798,478	933,152	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
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	1,584,505					14.00
15.00	01500	PHARMACY	6,075	2,871,767				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,412,802			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	61,120		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,947	0	110,516	36,741	11,471,160	30.00
31.00	03100	INTENSIVE CARE UNIT	13,673	0	23,530	1,342	1,628,855	31.00
43.00	04300	NURSERY	0	0	11,767	3,825	689,258	43.00
44.00	04400	SKILLED NURSING FACILITY	21,877	0	56,281	0	6,174,372	44.00
45.00	04500	NURSING FACILITY	863	0	11,654	0	1,345,676	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	120,526	0	106,993	19,212	4,801,463	50.00
53.00	05300	ANESTHESIOLOGY	5,925	0	17,773	0	161,164	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,784	0	61,751	0	2,345,136	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,383	0	15,006	0	411,215	55.00
57.00	05700	CT SCAN	6,890	0	95,368	0	589,240	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	386	0	23,240	0	274,483	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,100	0	62,170	0	1,747,873	59.00
60.00	06000	LABORATORY	316,218	0	186,462	0	8,362,452	60.00
65.00	06500	RESPIRATORY THERAPY	17,104	0	99,354	0	2,201,745	65.00
66.00	06600	PHYSICAL THERAPY	2,924	0	57,570	0	3,557,989	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	305,703	0	38,859	0	2,323,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	590,519	0	75,434	0	4,487,949	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,871,767	121,171	0	6,751,515	73.00
76.00	03020	CARDIAC REHAB	648	0	5,107	0	1,328,344	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1	0	568	0	133,661	90.00
90.01	09001	WOUND CENTER	3,624	0	5,061	0	389,435	90.01
91.00	09100	EMERGENCY	35,325	0	170,136	0	3,817,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	11,918	0	50,945	0	3,665,888	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,584,413	2,871,767	1,406,716	61,120	68,659,746	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	156,392	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	596,687	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	193,009	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	6,086	0	910,967	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	1,421,994	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	876,796	194.03
194.04	07951	OUTREACH	92	0	0	0	261,925	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,584,505	2,871,767	1,412,802	61,120	73,077,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP RELATED IRC				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT IRC				7.01
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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	11,471,160		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,628,855		31.00
43.00	04300	NURSERY	0	689,258		43.00
44.00	04400	SKILLED NURSING FACILITY	0	6,174,372		44.00
45.00	04500	NURSING FACILITY	0	1,345,676		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,801,463		50.00
53.00	05300	ANESTHESIOLOGY	0	161,164		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,345,136		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	411,215		55.00
57.00	05700	CT SCAN	0	589,240		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	274,483		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,747,873		59.00
60.00	06000	LABORATORY	0	8,362,452		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,201,745		65.00
66.00	06600	PHYSICAL THERAPY	0	3,557,989		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,323,002		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,487,949		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,751,515		73.00
76.00	03020	CARDIAC REHAB	0	1,328,344		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	133,661		90.00
90.01	09001	WOUND CENTER	0	389,435		90.01
91.00	09100	EMERGENCY	0	3,817,871		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	3,665,888		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	68,659,746		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	156,392		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	596,687		192.00
192.01	19201	NONREIMBURSABLE	0	193,009		192.01
194.00	07950	CROSSTOWN SQUARE	0	910,967		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	1,421,994		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	876,796		194.03
194.04	07951	OUTREACH	0	261,925		194.04
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)	0	73,077,516		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,502	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	253,709	144,210	0	99,451	0	5.00
7.00	00700	OPERATION OF PLANT	475,670	2,501,274	0	84,892	0	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	16,723	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,423	1,349	0	0	8.00
9.00	00900	HOUSEKEEPING	0	2,930	2,952	6,438	0	9.00
10.00	01000	DIETARY	3,618	14,169	0	6,371	0	10.00
11.00	01100	CAFETERIA	0	7,866	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,148	2,093	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,053	17,944	0	86,962	0	14.00
15.00	01500	PHARMACY	72,890	12,449	0	120,782	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,384	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,962	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,749	115,405	0	233,334	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,380	10,034	0	13,614	0	31.00
43.00	04300	NURSERY	0	5,819	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	34,926	0	223,138	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	107,501	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,884	43,215	0	257,774	0	50.00
53.00	05300	ANESTHESIOLOGY	11,687	0	0	67,544	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,732	23,766	0	305,003	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	336	0	0	35,429	0	55.00
57.00	05700	CT SCAN	49,200	0	0	80,942	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	84,191	488	0	3,231	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	82,606	6,461	0	262,483	0	59.00
60.00	06000	LABORATORY	174,049	40,202	0	168,923	0	60.00
65.00	06500	RESPIRATORY THERAPY	56,909	7,545	0	130,782	0	65.00
66.00	06600	PHYSICAL THERAPY	115,891	9,085	30,113	30,756	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	184,021	23,342	0	13,860	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,355	0	0	1,278	0	90.00
90.01	09001	WOUND CENTER	30,358	5,079	0	3,816	0	90.01
91.00	09100	EMERGENCY	15,293	23,707	0	69,839	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	123,348	19,052	0	231,223	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,949,003	3,054,406	381,776	2,314,727	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	60	4,279	2,639	630	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	238,808	1,942	0	72	0	192.00
192.01	19201	NONREIMBURSABLE	0	0	6,404	97	0	192.01
194.00	07950	CROSSTOWN SQUARE	1,695	0	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,189,566	3,060,627	390,819	2,315,526	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,502	1,502				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	497,370	48	497,418			5.00
7.00	00700	OPERATION OF PLANT	3,061,836	50	48,551	3,110,437		7.00
7.01	00701	OPERATION OF PLANT IRC	16,723	0	140	0	16,863	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	7,772	2	615	48,299	61	8.00
9.00	00900	HOUSEKEEPING	12,320	27	5,200	22,031	133	9.00
10.00	01000	DIETARY	24,158	8	3,972	106,545	0	10.00
11.00	01100	CAFETERIA	7,866	0	66	59,153	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,241	32	5,984	15,737	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	186,959	5	8,371	134,931	0	14.00
15.00	01500	PHARMACY	206,121	81	17,809	93,613	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,384	0	8,642	55,522	0	16.00
17.00	01700	SOCIAL SERVICE	2,962	0	25	22,273	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	387,488	250	55,976	867,814	0	30.00
31.00	03100	INTENSIVE CARE UNIT	26,028	43	8,898	75,455	0	31.00
43.00	04300	NURSERY	5,819	18	3,660	43,760	0	43.00
44.00	04400	SKILLED NURSING FACILITY	258,064	174	38,615	0	10,058	44.00
45.00	04500	NURSING FACILITY	107,501	21	8,595	0	4,846	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	349,873	81	24,322	324,960	0	50.00
53.00	05300	ANESTHESIOLOGY	79,231	0	936	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	331,501	48	12,136	178,711	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	35,765	4	2,473	0	0	55.00
57.00	05700	CT SCAN	130,142	10	3,257	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	87,910	5	1,624	3,672	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	351,550	19	10,362	48,582	0	59.00
60.00	06000	LABORATORY	383,174	108	47,961	302,304	0	60.00
65.00	06500	RESPIRATORY THERAPY	195,236	56	12,972	56,732	0	65.00
66.00	06600	PHYSICAL THERAPY	185,845	110	22,206	68,313	1,357	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	13,467	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	26,017	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	25,585	0	0	73.00
76.00	03020	CARDIAC REHAB	221,223	21	5,863	175,523	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,633	5	888	0	0	90.00
90.01	09001	WOUND CENTER	39,253	3	1,883	38,191	0	90.01
91.00	09100	EMERGENCY	108,839	95	20,268	178,267	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	373,623	117	21,416	143,263	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,699,912	1,441	468,755	3,063,651	16,455	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,608	0	482	32,179	119	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	240,822	2	3,789	14,607	0	192.00
192.01	19201	NONREIMBURSABLE	6,501	0	1,276	0	289	192.01
194.00	07950	CROSSTOWN SQUARE	1,695	16	6,009	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	21	9,499	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	13	5,882	0	0	194.03
194.04	07951	OUTREACH	0	9	1,726	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,956,538	1,502	497,418	3,110,437	16,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	56,749					8.00
9.00	00900	HOUSEKEEPING	0	39,711				9.00
10.00	01000	DIETARY	0	1,492	136,175			10.00
11.00	01100	CAFETERIA	0	828	100,922	168,835		11.00
13.00	01300	NURSING ADMINISTRATION	0	220	0	2,851	31,065	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	457	1,889	0	1,035	0	14.00
15.00	01500	PHARMACY	0	447	0	5,406	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	777	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	312	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,896	12,153	33,406	31,202	13,229	30.00
31.00	03100	INTENSIVE CARE UNIT	903	1,057	1,847	4,436	1,750	31.00
43.00	04300	NURSERY	3,926	613	0	1,921	0	43.00
44.00	04400	SKILLED NURSING FACILITY	18,700	0	0	26,084	7,375	44.00
45.00	04500	NURSING FACILITY	1,767	0	0	3,867	1,330	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,280	4,550	0	8,397	2,469	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,853	2,502	0	5,373	2	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	314	0	55.00
57.00	05700	CT SCAN	1,121	0	0	944	1	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	260	51	0	389	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	518	680	0	1,607	350	59.00
60.00	06000	LABORATORY	10	2,500	0	13,695	159	60.00
65.00	06500	RESPIRATORY THERAPY	596	794	0	6,549	6	65.00
66.00	06600	PHYSICAL THERAPY	543	1,141	0	10,912	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	98	1,669	0	2,280	448	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	562	0	90.00
90.01	09001	WOUND CENTER	27	535	0	395	119	90.01
91.00	09100	EMERGENCY	7,554	2,496	0	9,877	3,377	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,006	0	17,922	80	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,509	38,712	136,175	156,018	30,695	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	551	0	82	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	240	205	0	333	0	192.00
192.01	19201	NONREIMBURSABLE	0	243	0	36	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	2,332	370	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	5,605	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	2,685	0	194.03
194.04	07951	OUTREACH	0	0	0	1,744	0	194.04
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)	56,749	39,711	136,175	168,835	31,065	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
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	333,647					14.00
15.00	01500	PHARMACY	1,279	324,756				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	72,325			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	25,572		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,939	0	5,653	15,372	1,446,378	30.00
31.00	03100	INTENSIVE CARE UNIT	2,879	0	1,204	562	125,062	31.00
43.00	04300	NURSERY	0	0	602	1,600	61,919	43.00
44.00	04400	SKILLED NURSING FACILITY	4,607	0	2,879	0	366,556	44.00
45.00	04500	NURSING FACILITY	182	0	596	0	128,705	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,379	0	5,473	8,038	761,822	50.00
53.00	05300	ANESTHESIOLOGY	1,248	0	909	0	82,324	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	797	0	3,159	0	537,082	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,608	0	768	0	45,932	55.00
57.00	05700	CT SCAN	1,451	0	4,878	0	141,804	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	81	0	1,189	0	95,181	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,811	0	3,180	0	420,659	59.00
60.00	06000	LABORATORY	66,586	0	9,594	0	826,091	60.00
65.00	06500	RESPIRATORY THERAPY	3,602	0	5,082	0	281,625	65.00
66.00	06600	PHYSICAL THERAPY	616	0	2,945	0	293,988	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	64,372	0	1,988	0	79,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,343	0	3,859	0	154,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	324,756	6,198	0	356,539	73.00
76.00	03020	CARDIAC REHAB	137	0	261	0	407,523	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	29	0	4,117	90.00
90.01	09001	WOUND CENTER	763	0	259	0	81,428	90.01
91.00	09100	EMERGENCY	7,438	0	8,703	0	346,914	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,510	0	2,606	0	563,543	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	333,628	324,756	72,014	25,572	7,609,238	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	41,021	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	259,998	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	8,345	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	311	0	10,733	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	15,125	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	8,580	194.03
194.04	07951	OUTREACH	19	0	0	0	3,498	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	333,647	324,756	72,325	25,572	7,956,538	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP RELATED IRC				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT IRC				7.01
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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,446,378		30.00
31.00	03100	INTENSIVE CARE UNIT	0	125,062		31.00
43.00	04300	NURSERY	0	61,919		43.00
44.00	04400	SKILLED NURSING FACILITY	0	366,556		44.00
45.00	04500	NURSING FACILITY	0	128,705		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	761,822		50.00
53.00	05300	ANESTHESIOLOGY	0	82,324		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	537,082		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	45,932		55.00
57.00	05700	CT SCAN	0	141,804		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	95,181		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	420,659		59.00
60.00	06000	LABORATORY	0	826,091		60.00
65.00	06500	RESPIRATORY THERAPY	0	281,625		65.00
66.00	06600	PHYSICAL THERAPY	0	293,988		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79,827		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	154,219		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	356,539		73.00
76.00	03020	CARDIAC REHAB	0	407,523		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	4,117		90.00
90.01	09001	WOUND CENTER	0	81,428		90.01
91.00	09100	EMERGENCY	0	346,914		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	563,543		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,609,238		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	41,021		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	259,998		192.00
192.01	19201	NONREIMBURSABLE	0	8,345		192.01
194.00	07950	CROSSTOWN SQUARE	0	10,733		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	15,125		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	8,580		194.03
194.04	07951	OUTREACH	0	3,498		194.04
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)	0	7,956,538		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP RELATED IRC (SQUARE FEET IRC)	NEW MVBLE EQUIP (DOLLAR VALUE)	MVBLE EQUIP IRC (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,140,760					1.00
1.01	00101	NEW CAP RELATED IRC	0	52,420				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,129,132			2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC			0	0		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	560	0	0	0	28,054,350	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,750	0	91,445	0	895,151	5.00
7.00	00700	OPERATION OF PLANT	932,278	0	78,058	0	932,278	7.00
7.01	00701	OPERATION OF PLANT IRC	0	2,243	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,394	181	0	0	30,713	8.00
9.00	00900	HOUSEKEEPING	1,092	396	5,920	0	490,957	9.00
10.00	01000	DIETARY	5,281	0	5,858	0	157,377	10.00
11.00	01100	CAFETERIA	2,932	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	780	0	0	0	583,521	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	79,962	0	95,330	14.00
15.00	01500	PHARMACY	4,640	0	111,059	0	1,495,929	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,014	0	214,551	0	4,881,865	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	0	12,518	0	790,815	31.00
43.00	04300	NURSERY	2,169	0	0	0	328,488	43.00
44.00	04400	SKILLED NURSING FACILITY	0	29,929	0	0	3,228,084	44.00
45.00	04500	NURSING FACILITY	0	14,419	0	0	387,043	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,107	0	237,024	0	1,507,381	50.00
53.00	05300	ANESTHESIOLOGY	0	0	62,107	0	11	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	280,454	0	894,732	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	32,577	0	75,252	55.00
57.00	05700	CT SCAN	0	0	74,426	0	183,531	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	2,971	0	86,850	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	241,354	0	346,823	59.00
60.00	06000	LABORATORY	14,984	0	155,325	0	1,992,802	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	0	120,254	0	1,031,775	65.00
66.00	06600	PHYSICAL THERAPY	3,386	4,039	28,280	0	2,032,736	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	8,700	0	12,744	0	396,057	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,175	0	86,734	90.00
90.01	09001	WOUND CENTER	1,893	0	3,509	0	57,425	90.01
91.00	09100	EMERGENCY	8,836	0	64,217	0	1,762,819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,101	0	212,610	0	2,172,112	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,138,441	51,207	2,128,398	0	26,924,591	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,595	354	579	0	7,020	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	66	0	30,605	192.00
192.01	19201	NONREIMBURSABLE	0	859	89	0	3,094	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	0	288,879	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	393,473	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	243,642	194.03
194.04	07951	OUTREACH	0	0	0	0	163,046	194.04
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)	3,060,627	390,819	2,315,526	0	2,957,819	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.682972	7.455532	1.087545	0.000000	0.105432	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					1,502	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000054	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT IRC (SQUARE FEET IRC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,745,005	59,332,511				5.00
7.00	00700	OPERATION OF PLANT	0	5,790,962	154,172			7.00
7.01	00701	OPERATION OF PLANT IRC	0	16,723	0	50,177		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,397	2,394	181	735,854	8.00
9.00	00900	HOUSEKEEPING	0	620,184	1,092	396	0	9.00
10.00	01000	DIETARY	0	473,711	5,281	0	0	10.00
11.00	01100	CAFETERIA	0	7,866	2,932	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	713,721	780	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	998,508	6,688	0	5,930	14.00
15.00	01500	PHARMACY	0	2,124,198	4,640	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,030,753	2,752	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,962	1,104	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,679,321	43,014	0	115,356	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,061,358	3,740	0	11,713	31.00
43.00	04300	NURSERY	0	436,604	2,169	0	50,911	43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,605,749	0	29,929	242,482	44.00
45.00	04500	NURSING FACILITY	0	1,025,224	0	14,419	22,907	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,900,964	16,107	0	107,361	50.00
53.00	05300	ANESTHESIOLOGY	0	111,609	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,447,550	8,858	0	36,995	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	294,999	0	0	0	55.00
57.00	05700	CT SCAN	0	388,515	0	0	14,533	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	193,740	182	0	3,371	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,235,978	2,408	0	6,714	59.00
60.00	06000	LABORATORY	0	5,720,494	14,984	0	135	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,547,207	2,812	0	7,733	65.00
66.00	06600	PHYSICAL THERAPY	0	2,648,661	3,386	4,039	7,038	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,606,319	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,103,123	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,051,633	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	699,283	8,700	0	1,270	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	105,902	0	0	0	90.00
90.01	09001	WOUND CENTER	0	224,627	1,893	0	351	90.01
91.00	09100	EMERGENCY	0	2,417,454	8,836	0	97,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,554,448	7,101	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-13,745,005	55,913,747	151,853	48,964	732,748	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57,465	1,595	354	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	451,879	724	0	3,106	192.00
192.01	19201	NONREIMBURSABLE	0	152,240	0	859	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	716,709	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	1,133,012	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	701,571	0	0	0	194.03
194.04	07951	OUTREACH	0	205,888	0	0	0	194.04
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)		13,745,005	7,132,502	20,597	201,228	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.231661	46.263277	0.410487	0.273462	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		497,418	3,110,437	16,863	56,749	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.008384	20.175110	0.336070	0.077120	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	140,569					9.00
10.00	01000	DIETARY	5,281	156,665				10.00
11.00	01100	CAFETERIA	2,932	116,108	51,691			11.00
13.00	01300	NURSING ADMINISTRATION	780	0	873	484,521		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	317	0	8,326,475	14.00
15.00	01500	PHARMACY	1,583	0	1,655	0	31,923	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,014	38,432	9,553	206,353	372,823	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	2,125	1,358	27,289	71,852	31.00
43.00	04300	NURSERY	2,169	0	588	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	7,986	115,029	114,964	44.00
45.00	04500	NURSING FACILITY	0	0	1,184	20,748	4,536	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,107	0	2,571	38,505	633,358	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1	31,138	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	1,645	28	19,887	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	96	2	164,917	55.00
57.00	05700	CT SCAN	0	0	289	13	36,209	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	119	0	2,027	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	492	5,455	95,113	59.00
60.00	06000	LABORATORY	8,850	0	4,193	2,474	1,661,707	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	0	2,005	93	89,882	65.00
66.00	06600	PHYSICAL THERAPY	4,039	0	3,341	0	15,364	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,606,454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,103,123	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	5,908	0	698	6,986	3,407	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	172	0	6	90.00
90.01	09001	WOUND CENTER	1,893	0	121	1,857	19,042	90.01
91.00	09100	EMERGENCY	8,836	0	3,024	52,674	185,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,101	0	5,487	1,241	62,630	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	137,037	156,665	47,767	478,748	8,325,991	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,949	0	25	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	102	5	0	192.00
192.01	19201	NONREIMBURSABLE	859	0	11	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	714	5,768	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	1,716	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	822	0	0	194.03
194.04	07951	OUTREACH	0	0	534	0	484	194.04
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)	814,538	858,368	798,478	933,152	1,584,505	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.794578	5.479003	15.447138	1.925927	0.190297	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,711	136,175	168,835	31,065	333,647	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.282502	0.869211	3.266236	0.064115	0.040071	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/20/2014 3:21 pm

		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
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	3,051,633				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	201,314,461			16.00
17.00	01700	SOCIAL SERVICE	0	0	7,877		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	15,747,510	4,735		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,352,759	173		31.00
43.00	04300	NURSERY	0	1,676,756	493		43.00
44.00	04400	SKILLED NURSING FACILITY	0	8,019,470	0		44.00
45.00	04500	NURSING FACILITY	0	1,660,567	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	15,245,570	2,476		50.00
53.00	05300	ANESTHESIOLOGY	0	2,532,543	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,798,875	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,138,192	0		55.00
57.00	05700	CT SCAN	0	13,588,989	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,311,452	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,858,664	0		59.00
60.00	06000	LABORATORY	0	26,572,442	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	14,156,965	0		65.00
66.00	06600	PHYSICAL THERAPY	0	8,203,171	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,537,098	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,748,646	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,051,633	17,265,683	0		73.00
76.00	03020	CARDIAC REHAB	0	727,705	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	80,973	0		90.00
90.01	09001	WOUND CENTER	0	721,172	0		90.01
91.00	09100	EMERGENCY	0	24,242,799	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	7,259,218	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,051,633	200,447,219	7,877		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	NONREIMBURSABLE	0	0	0		192.01
194.00	07950	CROSSTOWN SQUARE	0	867,242	0		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0		194.03
194.04	07951	OUTREACH	0	0	0		194.04
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)	2,871,767	1,412,802	61,120		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.941059	0.007018	7.759299		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	324,756	72,325	25,572		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.106420	0.000359	3.246414		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,471,160		11,471,160	0	11,471,160	30.00
31.00	03100	INTENSIVE CARE UNIT	1,628,855		1,628,855	0	1,628,855	31.00
43.00	04300	NURSERY	689,258		689,258	0	689,258	43.00
44.00	04400	SKILLED NURSING FACILITY	6,174,372		6,174,372	0	6,174,372	44.00
45.00	04500	NURSING FACILITY	1,345,676		1,345,676	0	1,345,676	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,801,463		4,801,463	0	4,801,463	50.00
53.00	05300	ANESTHESIOLOGY	161,164		161,164	0	161,164	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,345,136		2,345,136	0	2,345,136	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	411,215		411,215	0	411,215	55.00
57.00	05700	CT SCAN	589,240		589,240	0	589,240	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	274,483		274,483	0	274,483	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,747,873		1,747,873	0	1,747,873	59.00
60.00	06000	LABORATORY	8,362,452		8,362,452	0	8,362,452	60.00
65.00	06500	RESPIRATORY THERAPY	2,201,745	0	2,201,745	0	2,201,745	65.00
66.00	06600	PHYSICAL THERAPY	3,557,989	0	3,557,989	0	3,557,989	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,323,002		2,323,002	0	2,323,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,487,949		4,487,949	0	4,487,949	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,751,515		6,751,515	0	6,751,515	73.00
76.00	03020	CARDIAC REHAB	1,328,344		1,328,344	0	1,328,344	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	133,661		133,661	0	133,661	90.00
90.01	09001	WOUND CENTER	389,435		389,435	0	389,435	90.01
91.00	09100	EMERGENCY	3,817,871		3,817,871	0	3,817,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,549,733		1,549,733		1,549,733	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,665,888		3,665,888	0	3,665,888	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	70,209,479	0	70,209,479	0	70,209,479	200.00
201.00		Less Observation Beds	1,549,733		1,549,733		1,549,733	201.00
202.00		Total (see instructions)	68,659,746	0	68,659,746	0	68,659,746	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,747,510		15,747,510			30.00
31.00	03100	INTENSIVE CARE UNIT	3,352,759		3,352,759			31.00
43.00	04300	NURSERY	1,676,756		1,676,756			43.00
44.00	04400	SKILLED NURSING FACILITY	8,019,470		8,019,470			44.00
45.00	04500	NURSING FACILITY	1,660,567		1,660,567			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,667,866	9,577,704	15,245,570	0.314942	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	925,057	1,607,486	2,532,543	0.063637	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,172	7,138,703	8,798,875	0.266527	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	181,251	1,956,941	2,138,192	0.192319	0.000000	55.00
57.00	05700	CT SCAN	3,005,801	10,583,188	13,588,989	0.043362	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	492,837	2,818,615	3,311,452	0.082889	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,548,206	5,310,458	8,858,664	0.197307	0.000000	59.00
60.00	06000	LABORATORY	7,215,614	19,356,828	26,572,442	0.314704	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,367,224	5,789,741	14,156,965	0.155524	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,127,024	3,076,148	8,203,172	0.433733	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,249,384	2,287,715	5,537,099	0.419534	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,308,956	4,439,690	10,748,646	0.417536	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,949,767	8,315,915	17,265,682	0.391037	0.000000	73.00
76.00	03020	CARDIAC REHAB	24,506	703,199	727,705	1.825388	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,023	75,931	80,954	1.651073	0.000000	90.00
90.01	09001	WOUND CENTER	3,096	718,095	721,191	0.539989	0.000000	90.01
91.00	09100	EMERGENCY	4,768,394	19,474,405	24,242,799	0.157485	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	247,973	2,001,479	2,249,452	0.688938	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,259,218	7,259,218	0.504998	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	90,205,213	112,491,459	202,696,672			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	90,205,213	112,491,459	202,696,672			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.314942		50.00
53.00	05300	ANESTHESIOLOGY	0.063637		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266527		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.192319		55.00
57.00	05700	CT SCAN	0.043362		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.082889		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.197307		59.00
60.00	06000	LABORATORY	0.314704		60.00
65.00	06500	RESPIRATORY THERAPY	0.155524		65.00
66.00	06600	PHYSICAL THERAPY	0.433733		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.419534		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417536		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391037		73.00
76.00	03020	CARDIAC REHAB	1.825388		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1.651073		90.00
90.01	09001	WOUND CENTER	0.539989		90.01
91.00	09100	EMERGENCY	0.157485		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.688938		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.504998		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/20/2014 3:21 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	11,471,160		11,471,160	0	11,471,160	30.00
31.00	03100	INTENSIVE CARE UNIT	1,628,855		1,628,855	0	1,628,855	31.00
43.00	04300	NURSERY	689,258		689,258	0	689,258	43.00
44.00	04400	SKILLED NURSING FACILITY	6,174,372		6,174,372	0	6,174,372	44.00
45.00	04500	NURSING FACILITY	1,345,676		1,345,676	0	1,345,676	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,801,463		4,801,463	0	4,801,463	50.00
53.00	05300	ANESTHESIOLOGY	161,164		161,164	0	161,164	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,345,136		2,345,136	0	2,345,136	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	411,215		411,215	0	411,215	55.00
57.00	05700	CT SCAN	589,240		589,240	0	589,240	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	274,483		274,483	0	274,483	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,747,873		1,747,873	0	1,747,873	59.00
60.00	06000	LABORATORY	8,362,452		8,362,452	0	8,362,452	60.00
65.00	06500	RESPIRATORY THERAPY	2,201,745	0	2,201,745	0	2,201,745	65.00
66.00	06600	PHYSICAL THERAPY	3,557,989	0	3,557,989	0	3,557,989	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,323,002		2,323,002	0	2,323,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,487,949		4,487,949	0	4,487,949	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,751,515		6,751,515	0	6,751,515	73.00
76.00	03020	CARDIAC REHAB	1,328,344		1,328,344	0	1,328,344	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	133,661		133,661	0	133,661	90.00
90.01	09001	WOUND CENTER	389,435		389,435	0	389,435	90.01
91.00	09100	EMERGENCY	3,817,871		3,817,871	0	3,817,871	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,549,733		1,549,733		1,549,733	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,665,888		3,665,888	0	3,665,888	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	70,209,479	0	70,209,479	0	70,209,479	200.00
201.00		Less Observation Beds	1,549,733		1,549,733		1,549,733	201.00
202.00		Total (see instructions)	68,659,746	0	68,659,746	0	68,659,746	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/20/2014 3:21 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	15,747,510		15,747,510			30.00
31.00	03100	INTENSIVE CARE UNIT	3,352,759		3,352,759			31.00
43.00	04300	NURSERY	1,676,756		1,676,756			43.00
44.00	04400	SKILLED NURSING FACILITY	8,019,470		8,019,470			44.00
45.00	04500	NURSING FACILITY	1,660,567		1,660,567			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,667,866	9,577,704	15,245,570	0.314942	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	925,057	1,607,486	2,532,543	0.063637	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,660,172	7,138,703	8,798,875	0.266527	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	181,251	1,956,941	2,138,192	0.192319	0.000000	55.00
57.00	05700	CT SCAN	3,005,801	10,583,188	13,588,989	0.043362	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	492,837	2,818,615	3,311,452	0.082889	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,548,206	5,310,458	8,858,664	0.197307	0.000000	59.00
60.00	06000	LABORATORY	7,215,614	19,356,828	26,572,442	0.314704	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,367,224	5,789,741	14,156,965	0.155524	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,127,024	3,076,148	8,203,172	0.433733	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,249,384	2,287,715	5,537,099	0.419534	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,308,956	4,439,690	10,748,646	0.417536	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,949,767	8,315,915	17,265,682	0.391037	0.000000	73.00
76.00	03020	CARDIAC REHAB	24,506	703,199	727,705	1.825388	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,023	75,931	80,954	1.651073	0.000000	90.00
90.01	09001	WOUND CENTER	3,096	718,095	721,191	0.539989	0.000000	90.01
91.00	09100	EMERGENCY	4,768,394	19,474,405	24,242,799	0.157485	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	247,973	2,001,479	2,249,452	0.688938	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,259,218	7,259,218	0.504998	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	90,205,213	112,491,459	202,696,672			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	90,205,213	112,491,459	202,696,672			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/20/2014 3:21 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
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CENTER	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part I Date/Time Prepared: 11/20/2014 3:21 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	1,446,378	0	1,446,378	12,354	117.08	30.00
31.00	INTENSIVE CARE UNIT	125,062		125,062	1,059	118.09	31.00
43.00	NURSERY	61,919		61,919	1,363	45.43	43.00
44.00	SKILLED NURSING FACILITY	366,556		366,556	27,471	13.34	44.00
45.00	NURSING FACILITY	128,705		128,705	10,693	12.04	45.00
200.00	Total (lines 30-199)	2,128,620		2,128,620	52,940		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	5,238	613,265				30.00
31.00	INTENSIVE CARE UNIT	537	63,414				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	8,198	109,361				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30-199)	13,973	786,040				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/20/2014 3:21 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	761,822	15,245,570	0.049970	2,229,441	111,405	50.00
53.00	05300	ANESTHESIOLOGY	82,324	2,532,543	0.032506	321,061	10,436	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	537,082	8,798,875	0.061040	645,704	39,414	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	45,932	2,138,192	0.021482	116,772	2,508	55.00
57.00	05700	CT SCAN	141,804	13,588,989	0.010435	970,481	10,127	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	95,181	3,311,452	0.028743	218,216	6,272	58.00
59.00	05900	CARDIAC CATHETERIZATION	420,659	8,858,664	0.047486	1,952,429	92,713	59.00
60.00	06000	LABORATORY	826,091	26,572,442	0.031088	2,898,111	90,096	60.00
65.00	06500	RESPIRATORY THERAPY	281,625	14,156,965	0.019893	4,497,328	89,465	65.00
66.00	06600	PHYSICAL THERAPY	293,988	8,203,172	0.035838	674,320	24,166	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	79,827	5,537,099	0.014417	1,485,120	21,411	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	154,219	10,748,646	0.014348	3,623,680	51,993	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356,539	17,265,682	0.020650	4,412,750	91,123	73.00
76.00	03020	CARDIAC REHAB	407,523	727,705	0.560011	13,877	7,771	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,117	80,954	0.050856	1,445	73	90.00
90.01	09001	WOUND CENTER	81,428	721,191	0.112908	3,096	350	90.01
91.00	09100	EMERGENCY	346,914	24,242,799	0.014310	2,562,311	36,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	195,403	2,249,452	0.086867	147,042	12,773	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,112,478	164,980,392		26,773,184	698,763	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part III Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
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	12,354	0.00	5,238	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,059	0.00	537	0		31.00
43.00	04300	NURSERY	1,363	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	27,471	0.00	8,198	0		44.00
45.00	04500	NURSING FACILITY	10,693	0.00	0	0		45.00
200.00		Total (lines 30-199)	52,940		13,973	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/20/2014 3:21 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	90.01
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/20/2014 3:21 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	15,245,570	0.000000	0.000000	2,229,441	50.00
53.00	05300	ANESTHESIOLOGY	0	2,532,543	0.000000	0.000000	321,061	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,798,875	0.000000	0.000000	645,704	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,138,192	0.000000	0.000000	116,772	55.00
57.00	05700	CT SCAN	0	13,588,989	0.000000	0.000000	970,481	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,311,452	0.000000	0.000000	218,216	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,858,664	0.000000	0.000000	1,952,429	59.00
60.00	06000	LABORATORY	0	26,572,442	0.000000	0.000000	2,898,111	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,156,965	0.000000	0.000000	4,497,328	65.00
66.00	06600	PHYSICAL THERAPY	0	8,203,172	0.000000	0.000000	674,320	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,537,099	0.000000	0.000000	1,485,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,748,646	0.000000	0.000000	3,623,680	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,265,682	0.000000	0.000000	4,412,750	73.00
76.00	03020	CARDIAC REHAB	0	727,705	0.000000	0.000000	13,877	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	80,954	0.000000	0.000000	1,445	90.00
90.01	09001	WOUND CENTER	0	721,191	0.000000	0.000000	3,096	90.01
91.00	09100	EMERGENCY	0	24,242,799	0.000000	0.000000	2,562,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,249,452	0.000000	0.000000	147,042	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	164,980,392			26,773,184	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/20/2014 3:21 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	2,248,821	0		50.00
53.00	05300	ANESTHESIOLOGY	0	347,289	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,510,527	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	501,614	0		55.00
57.00	05700	CT SCAN	0	2,997,142	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	448,152	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,581,720	0		59.00
60.00	06000	LABORATORY	0	1,642,679	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,984,681	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	749,108	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,416,813	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,293,393	0		73.00
76.00	03020	CARDIAC REHAB	0	326,974	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	13,416	0		90.00
90.01	09001	WOUND CENTER	0	310,524	0		90.01
91.00	09100	EMERGENCY	0	2,778,875	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	445,419	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	23,597,147	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/20/2014 3:21 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	0.314942	2,248,821	40	0	708,248	50.00
53.00	05300	ANESTHESIOLOGY	0.063637	347,289	0	0	22,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266527	1,510,527	0	0	402,596	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.192319	501,614	0	0	96,470	55.00
57.00	05700	CT SCAN	0.043362	2,997,142	0	0	129,962	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.082889	448,152	0	0	37,147	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.197307	2,581,720	0	0	509,391	59.00
60.00	06000	LABORATORY	0.314704	1,642,679	0	379	516,958	60.00
65.00	06500	RESPIRATORY THERAPY	0.155524	1,984,681	0	0	308,666	65.00
66.00	06600	PHYSICAL THERAPY	0.433733	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.419534	749,108	0	0	314,276	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417536	1,416,813	0	0	591,570	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391037	3,293,393	0	35,960	1,287,839	73.00
76.00	03020	CARDIAC REHAB	1.825388	326,974	0	0	596,854	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.651073	13,416	0	0	22,151	90.00
90.01	09001	WOUND CENTER	0.539989	310,524	0	0	167,680	90.01
91.00	09100	EMERGENCY	0.157485	2,778,875	0	0	437,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.688938	445,419	0	0	306,866	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.504998		0			95.00
200.00		Subtotal (see instructions)		23,597,147	40	36,339	6,456,405	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		23,597,147	40	36,339	6,456,405	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/20/2014 3:21 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	13	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	119		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,062		73.00
76.00	03020	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CENTER	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	13	14,181		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	13	14,181		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/20/2014 3:21 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	90.01
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 140275 | Component CCN: 145703 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/20/2014 3:21 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	15,245,570	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,532,543	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,798,875	0.000000	0.000000	43,537	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,138,192	0.000000	0.000000	0	55.00
57.00	05700	CT SCAN	0	13,588,989	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,311,452	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,858,664	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	26,572,442	0.000000	0.000000	102,780	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,156,965	0.000000	0.000000	75,106	65.00
66.00	06600	PHYSICAL THERAPY	0	8,203,172	0.000000	0.000000	2,776,514	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,537,099	0.000000	0.000000	6,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,748,646	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,265,682	0.000000	0.000000	504,911	73.00
76.00	03020	CARDIAC REHAB	0	727,705	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	80,954	0.000000	0.000000	0	90.00
90.01	09001	WOUND CENTER	0	721,191	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	24,242,799	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,249,452	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	164,980,392			3,509,539	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/20/2014 3:21 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
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CENTER	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/20/2014 3:21 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)	12,354	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,354	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)	10,685	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)	5,238	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)	11,471,160	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)	11,471,160	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)	11,471,160	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)	928.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,863,693	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)	4,863,693	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,628,855	1,059	1,538.11	537	825,965	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,662,335	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	13,351,993	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)	676,679	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	698,763	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,375,442	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,976,551	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)	1,669	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	928.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,549,733	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/20/2014 3:21 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	1,446,378	11,471,160	0.126088	1,549,733	195,403	90.00
91.00	Nursing School cost	0	11,471,160	0.000000	1,549,733	0	91.00
92.00	Allied health cost	0	11,471,160	0.000000	1,549,733	0	92.00
93.00	All other Medical Education	0	11,471,160	0.000000	1,549,733	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/20/2014 3:21 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)	27,471	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,471	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)	27,471	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,198	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)	6,174,372	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)	6,174,372	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)	6,174,372	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: 140275 | Component CCN: 145703 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/20/2014 3:21 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)	6,174,372	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	224.76	71.00
72.00	Program routine service cost (line 9 x line 71)	1,842,582	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,842,582	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,842,582	83.00
84.00	Program inpatient ancillary services (see instructions)	1,460,142	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)	3,302,724	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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1

Component CCN: 145703 | Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Skilled Nursing Facility | PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,085,276		30.00
31.00	03100	INTENSIVE CARE UNIT		1,853,146		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314942	2,229,441	702,145	50.00
53.00	05300	ANESTHESIOLOGY	0.063637	321,061	20,431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266527	645,704	172,098	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.192319	116,772	22,457	55.00
57.00	05700	CT SCAN	0.043362	970,481	42,082	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.082889	218,216	18,088	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.197307	1,952,429	385,228	59.00
60.00	06000	LABORATORY	0.314704	2,898,111	912,047	60.00
65.00	06500	RESPIRATORY THERAPY	0.155524	4,497,328	699,442	65.00
66.00	06600	PHYSICAL THERAPY	0.433733	674,320	292,475	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.419534	1,485,120	623,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417536	3,623,680	1,513,017	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391037	4,412,750	1,725,549	73.00
76.00	03020	CARDIAC REHAB	1.825388	13,877	25,331	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.651073	1,445	2,386	90.00
90.01	09001	WOUND CENTER	0.539989	3,096	1,672	90.01
91.00	09100	EMERGENCY	0.157485	2,562,311	403,526	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.688938	147,042	101,303	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		26,773,184	7,662,335	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)		26,773,184		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314942	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.063637	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.266527	43,537	11,604	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.192319	0	0	55.00
57.00	05700	CT SCAN	0.043362	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.082889	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.197307	0	0	59.00
60.00	06000	LABORATORY	0.314704	102,780	32,345	60.00
65.00	06500	RESPIRATORY THERAPY	0.155524	75,106	11,681	65.00
66.00	06600	PHYSICAL THERAPY	0.433733	2,776,514	1,204,266	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.419534	6,691	2,807	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417536	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.391037	504,911	197,439	73.00
76.00	03020	CARDIAC REHAB	1.825388	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.651073	0	0	90.00
90.01	09001	WOUND CENTER	0.539989	0	0	90.01
91.00	09100	EMERGENCY	0.157485	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.688938	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,509,539	1,460,142	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,509,539		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E Part A Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		2,640,017			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		9,340,566			1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0			1.03
2.00	Outlier payments for discharges. (see instructions)		32,564			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		144.43			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.10			30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.13			31.00
32.00	Sum of lines 30 and 31		27.23			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E Part A Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
33.00	Allowable disproportionate share percentage (see instructions)		11.68			33.00
34.00	Disproportionate share adjustment (see instructions)		581,099			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)				0	35.00
35.01	Factor 3 (see instructions)				0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				1,024,336	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				766,147	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		766,147			36.00
	Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		13,360,393			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 SCH and MDH only (see instructions)		13,360,393			49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,009,954			50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,370,347			59.00
60.00	Primary payer payments		14,420			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,355,927			61.00
62.00	Deductibles billed to program beneficiaries		1,475,758			62.00
63.00	Coinsurance billed to program beneficiaries		28,936			63.00
64.00	Allowable bad debts (see instructions)		242,542			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		157,652			65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E Part A Date/Time Prepared: 11/20/2014 3:21 pm

Title XVIII | Hospital | PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		195,883			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,008,885			67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.92	Bundled Model 1 discount amount		0			70.92
70.93	HVBP incentive payment (see instructions)		-12,027			70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-124,212			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,872,646			71.00
71.01	Sequestration adjustment (see instructions)		257,453			71.01
72.00	Interim payments		12,511,662			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		103,531			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0			90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140275	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/20/2014 3:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	14,194	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,456,405	2.00
3.00	PPS payments	6,149,924	3.00
4.00	Outlier payment (see instructions)	18,219	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	14,194	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	36,379	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	36,379	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)	36,379	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	22,185	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)	14,194	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)	6,168,143	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)	1,315,655	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	4,866,682	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,866,682	30.00
31.00	Primary payer payments	17,432	31.00
32.00	Subtotal (line 30 minus line 31)	4,849,250	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	203,412	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	132,218	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	158,100	36.00
37.00	Subtotal (see instructions)	4,981,468	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	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)	4,981,468	40.00
40.01	Sequestration adjustment (see instructions)	99,629	40.01
41.00	Interim payments	4,844,113	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	37,726	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2014 3:21 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		12,470,962		4,844,113	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	02/13/2014	40,700		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)		40,700		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)		12,511,662		4,844,113	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		103,531		37,726	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		12,615,193		4,881,839	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: 140275 Component CCN: 145703	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part I Date/Time Prepared: 11/20/2014 3:21 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		3,108,644		0	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)		3,108,644		0	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		1		0	6.02
7.00	Total Medicare program liability (see instructions)		3,108,643		0	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: 140275	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 11/20/2014 3:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	4,492	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	5,775	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	1,302	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	11,744	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	202,696,672	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	6,103,185	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	829,001	8.00
9.00	Sequestration adjustment amount (see instructions)	16,580	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	812,421	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	812,421	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VI Date/Time Prepared: 11/20/2014 3:21 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)	3,666,435	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)	3,666,435	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	479,824	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	3,186,611	12.00
13.00	Inpatient primary payer payments	14,526	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	3,172,085	15.00
15.01	Sequestration adjustment (see instructions)	63,442	15.01
16.00	Interim payments	3,108,644	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	-1	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/20/2014 3:21 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	14,524,412	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,798,789	0	0	0	4.00
5.00	Other receivable	11,992,667	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,185,371	0	0	0	7.00
8.00	Prepaid expenses	449,981	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	42,951,220	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,374,122	0	0	0	12.00
13.00	Land improvements	1,836,222	0	0	0	13.00
14.00	Accumulated depreciation	-1,567,022	0	0	0	14.00
15.00	Buildings	57,078,678	0	0	0	15.00
16.00	Accumulated depreciation	-34,233,851	0	0	0	16.00
17.00	Leasehold improvements	16,771	0	0	0	17.00
18.00	Accumulated depreciation	-10,946	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	45,000,085	0	0	0	23.00
24.00	Accumulated depreciation	-35,854,805	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)	34,639,254	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,001,871	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	8,497,002	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,498,873	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	89,089,347	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,166,899	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,565,429	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	710,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,905,669	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,347,997	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,515,607	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	10,515,607	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	23,863,604	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	65,225,743				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)	65,225,743	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	89,089,347	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/20/2014 3:21 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		65,512,284		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,231,054				2.00
3.00	Total (sum of line 1 and line 2)		57,281,230		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		57,281,230		0		11.00
12.00	DEDUCTIONS	7,944,509		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)		7,944,509		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,336,721		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	DEDUCTIONS		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: 140275 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/20/2014 3:21 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	19,888,612		19,888,612	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	8,019,470		8,019,470	7.00
8.00	NURSING FACILITY	1,660,567		1,660,567	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	29,568,649		29,568,649	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,474,658		3,474,658	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,474,658		3,474,658	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,043,307		33,043,307	17.00
18.00	Ancillary services	62,228,395	120,100,281	182,328,676	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CROSSTOWN SQUARE	867,242	0	867,242	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	96,138,944	120,100,281	216,239,225	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		87,315,598		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		87,315,598		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140275	Period: From 07/01/2013 To 06/30/2014	Worksheet G-3 Date/Time Prepared: 11/20/2014 3:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	216,239,225	1.00
2.00	Less contractual allowances and discounts on patients' accounts	125,827,877	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,411,348	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	87,315,598	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,095,750	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	-5,129,972	24.00
24.01	NONOPERATING GAINS & LOSSES	1,180,612	24.01
25.00	Total other income (sum of lines 6-24)	-3,949,360	25.00
26.00	Total (line 5 plus line 25)	-853,610	26.00
27.00	BAD DEBTS	7,377,444	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	7,377,444	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,231,054	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140275	Period: From 07/01/2013 To 06/30/2014	Worksheet L Parts I-III Date/Time Prepared: 11/20/2014 3:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	950,931	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,200	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)	32.65	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.10	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	25.13	8.00
9.00	Sum of lines 7 and 8	27.23	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.66	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	53,823	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,009,954	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