

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: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 12/1/2014 2:16 pm
--	----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 12/1/2014 Time: 2:16 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. ALEXIUS MEDICAL CENTER (140290) 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)

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	521,565	234,931	1,759,790	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	521,565	234,931	1,759,790	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: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet S-2 Part I Date/Time Prepared: 12/1/2014 2:15 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1555 BARRINGTON ROAD			PO Box:						1.00		
2.00	City: HOFFMAN ESTATES			State: IL		Zip Code: 60194		County: COOK		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		ST. ALEXIUS MEDICAL CENTER		140290	16974	1	09/16/1979	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											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)						1		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	N		22.01		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1	N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.		14,792	1,644	5	0	1,579		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		0	25.00		
						Urban/Rural S	Date of Geogr					
						1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 12/1/2014 2:15 pm		
		Beginning: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 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.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 12/1/2014 2:15 pm			
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20		
				1.00			
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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		
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>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.</u>							
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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet S-2 Part I Date/Time Prepared: 12/1/2014 2:15 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		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		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 12/1/2014 2:15 pm		
		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				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	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		N	120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149019	140.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 12/1/2014 2:15 pm			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ALEXIAN BROTHERS HOSPITAL NETWORK	Contractor's Name: WPS		Contractor's Number: 05901			
142.00	Street: 3040 SALT CREEK LANE	PO Box:					
143.00	City: ARLINGTON HEIGHTS,	State: IL	Zip Code: 60005				
				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.				Y	145.00	
				1.00			
				2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, 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			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	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
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.75	169.00	
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07/01/2014	09/30/2014	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 12/11/2014 2:15 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
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.	N			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	Type	Date
			1.00	2.00	3.00
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	Legal Oper.	
			1.00	2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N			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
			Y/N		
			1.00		
PS&R Data					
		Description	Part A		Part B
		0	Y/N	Date	Y/N
		1.00	2.00	3.00	
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: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 12/1/2014 2:15 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY		LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	LEONE CONSULTING			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	8472751023		TONY@LEONE-CONSULTING.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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.	CONSULTANT	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: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
12/1/2014 2:15 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	236	86,140	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)		236	86,140	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	27	9,855	0.00	0	8.00
8.01 NEONATAL NICU	31.01	16	5,840	0.00	0	8.01
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)		279	101,835	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						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		279				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
12/1/2014 2:15 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	25,474	9,300	58,234			1.00
2.00 HMO and other (see instructions)	2,761	3,228				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	25,474	9,300	58,234			7.00
8.00 INTENSIVE CARE UNIT	2,468	263	4,923			8.00
8.01 NEONATAL NICU	0	1,338	3,027			8.01
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		3,891	10,248			13.00
14.00 Total (see instructions)	27,942	14,792	76,432	0.00	1,414.55	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						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,414.55	27.00
28.00 Observation Bed Days		0	8,387			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
12/1/2014 2:15 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,316	3,222	15,991	1.00
2.00 HMO and other (see instructions)			548	349		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
8.01 NEONATAL NICU						8.01
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	5,316	3,222	15,991	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						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part II Date/Time Prepared: 12/1/2014 2:15 pm			
	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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	97,399,451	134	97,399,585	2,942,261.00	33.10	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		1,433,781	0	1,433,781	7,849.00	182.67	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		131,968	0	131,968	5,482.00	24.07	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		1,822,417	0	1,822,417	30,286.00	60.17	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		28,233,293	0	28,233,293	495,048.00	57.03	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)		21,751,715	0	21,751,715			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		9,578	0	9,578			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	90,750	0	90,750	2,632.00	34.48	26.00
27.00	Administrative & General	5.00	9,047,150	0	9,047,150	308,036.00	29.37	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	851,538	0	851,538	30,205.00	28.19	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	-134	134	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		2,741,133	0	2,741,133	123,054.00	22.28	33.00
34.00	Dietary	10.00	55,526	-16,658	38,868	995.00	39.06	34.00
35.00	Dietary under contract (see instructions)		3,851,358	0	3,851,358	158,935.00	24.23	35.00
36.00	Cafeteria	11.00	0	16,658	16,658	426.00	39.10	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,051,742	0	2,051,742	42,450.00	48.33	38.00
39.00	Central Services and Supply	14.00	438,035	0	438,035	20,443.00	21.43	39.00
40.00	Pharmacy	15.00	2,987,787	0	2,987,787	78,306.00	38.16	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part II
Date/Time Prepared:
12/1/2014 2:15 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	1,253,004	0	1,253,004	71,326.00	17.57	41.00
42.00	Social Service	17.00	2,353,178	0	2,353,178	63,830.00	36.87	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-3
Part III
Date/Time Prepared:
12/1/2014 2:15 pm

	Worksheet A	Amount	Recl assi fi cation	Adjusted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Salaries	Related to	Wage (col. 4 ÷	
	1.00	2.00	(from	(col. 2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	102,558,161	134	102,558,295	3,216,401.00	31.89	1.00
2.00	Excluded area salaries (see instructions)	131,968	0	131,968	5,482.00	24.07	2.00
3.00	Subtotal salaries (line 1 minus line 2)	102,426,193	134	102,426,327	3,210,919.00	31.90	3.00
4.00	Subtotal other wages & related costs (see inst.)	30,055,710	0	30,055,710	525,334.00	57.21	4.00
5.00	Subtotal wage-related costs (see inst.)	21,751,715	0	21,751,715	0.00	21.24	5.00
6.00	Total (sum of lines 3 thru 5)	154,233,618	134	154,233,752	3,736,253.00	41.28	6.00
7.00	Total overhead cost (see instructions)	25,721,067	134	25,721,201	900,638.00	28.56	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 12/1/2014 2:15 pm
-----------------------------	----------------------	---	--

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,292,121	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2,099,059	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)	9,301,159	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	596,774	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	232,941	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)	361,141	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	645,479	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	6,884,754	17.00
18.00	Medicare Taxes - Employers Portion Only	5,938	18.00
19.00	Unemployment Insurance	62,890	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	279,037	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,761,293	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part V Date/Time Prepared: 12/1/2014 2:15 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,822,417	0	1.00
2.00	Hospital	1,822,417	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-7

Date/Time Prepared:
12/1/2014 2:15 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-7

Date/Time Prepared:
12/1/2014 2:15 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet S-10 Date/Time Prepared: 12/1/2014 2:15 pm
---	----------------------	---	--

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.217043		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		58,753,647		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		230,403,573		6.00
7.00	Medicaid cost (line 1 times line 6)		50,007,483		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)		0		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)		0		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	45,456,935	5,212,519	50,669,454	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	9,866,110	1,131,341	10,997,451	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)	9,866,110	1,131,341	10,997,451	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)		16,205,139		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,066,614		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		15,138,525		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,285,711		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		14,283,162		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		14,283,162		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet A	
Date/Time Prepared: 12/1/2014 2:15 pm							
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		14,609,786	14,609,786	6,800,200	21,409,986	1.00
2.00	00200		0	0	10,861,369	10,861,369	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	90,750	14,085,446	14,176,196	645,479	14,821,675	4.00
5.00	00500	9,047,150	96,535,861	105,583,011	-3,052,672	102,530,339	5.00
7.00	00700	851,538	6,392,934	7,244,472	-20,261	7,224,211	7.00
8.00	00800	0	0	0	1,160,531	1,160,531	8.00
9.00	00900	-134	6,087,414	6,087,280	-1,166,017	4,921,263	9.00
10.00	01000	55,526	4,830,509	4,886,035	-1,465,811	3,420,224	10.00
11.00	01100	0	661,874	661,874	1,465,811	2,127,685	11.00
13.00	01300	2,051,742	375,818	2,427,560	0	2,427,560	13.00
14.00	01400	438,035	694,892	1,132,927	-376,832	756,095	14.00
15.00	01500	2,987,787	12,617,417	15,605,204	-11,889,040	3,716,164	15.00
16.00	01600	1,253,004	1,054,494	2,307,498	-161	2,307,337	16.00
17.00	01700	2,353,178	643,834	2,997,012	0	2,997,012	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	26,869,561	5,273,080	32,142,641	-821,288	31,321,353	30.00
31.00	03100	4,347,112	987,038	5,334,150	-348,171	4,985,979	31.00
31.01	02060	5,272,971	911,151	6,184,122	-167,437	6,016,685	31.01
43.00	04300	706,146	52,616	758,762	-13,716	745,046	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,996,087	8,487,534	13,483,621	-6,555,789	6,927,832	50.00
50.01	05001	1,435,150	1,514,710	2,949,860	-1,205,884	1,743,976	50.01
51.00	05100	1,150,090	180,021	1,330,111	-50,844	1,279,267	51.00
52.00	05200	3,557,263	970,742	4,528,005	-422,093	4,105,912	52.00
53.00	05300	74,269	386,317	460,586	-181,261	279,325	53.00
54.00	05400	2,684,669	444,491	3,129,160	-52,163	3,076,997	54.00
54.01	03630	1,161,882	159,621	1,321,503	-31,856	1,289,647	54.01
54.02	05401	697,817	706,743	1,404,560	-611,076	793,484	54.02
54.03	03440	1,030,211	750,121	1,780,332	-551,891	1,228,441	54.03
55.00	05500	815,235	317,706	1,132,941	-233,078	899,863	55.00
56.00	05600	462,633	902,312	1,364,945	-803,706	561,239	56.00
57.00	05700	1,017,174	471,592	1,488,766	-342,347	1,146,419	57.00
58.00	05800	728,420	1,031,828	1,760,248	-914,804	845,444	58.00
59.00	05900	1,625,110	2,857,859	4,482,969	-2,981,962	1,501,007	59.00
60.00	06000	2,551,875	4,885,052	7,436,927	-160,348	7,276,579	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	415,207	1,223,774	1,638,981	-4,279	1,634,702	63.00
64.00	06400	249,196	338,575	587,771	-248,351	339,420	64.00
65.00	06500	2,693,713	802,596	3,496,309	-373,801	3,122,508	65.00
66.00	06600	1,242,768	147,901	1,390,669	-60	1,390,609	66.00
66.01	06601	1,213,443	486,933	1,700,376	-288,201	1,412,175	66.01
67.00	06700	231,978	17,085	249,063	0	249,063	67.00
68.00	06800	122,056	8,927	130,983	0	130,983	68.00
69.00	06900	992,675	134,858	1,127,533	-15,069	1,112,464	69.00
70.00	07000	213,351	28,663	242,014	0	242,014	70.00
71.00	07100	0	0	0	12,508,022	12,508,022	71.00
72.00	07200	0	10,846,571	10,846,571	1,912,290	12,758,861	72.00
73.00	07300	0	0	0	11,576,257	11,576,257	73.00
74.00	07400	0	686,764	686,764	0	686,764	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	2,486,556	677,480	3,164,036	-386,257	2,777,779	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	116,242	427,831	544,073	0	544,073	90.04
90.05	09003	408,924	457,101	866,025	-352,462	513,563	90.05
91.00	09100	6,569,123	3,650,374	10,219,497	-797,702	9,421,795	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		9,261,924	9,261,924	-9,261,924	0	113.00
118.00		97,267,483	219,078,170	316,345,653	781,345	317,126,998	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	128,309	545,036	673,345	0	673,345	190.00
192.00	19200	0	4,578,922	4,578,922	0	4,578,922	192.00
192.01	19201	0	8,373,203	8,373,203	-781,345	7,591,858	192.01
194.00	07950	3,659	6,608	10,267	0	10,267	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		97,399,451	232,581,939	329,981,390	0	329,981,390	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,009,661	27,419,647	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-10,911,628	-50,259	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	48,984	14,870,659	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,555,124	88,975,215	5.00
7.00	00700	OPERATION OF PLANT	-393,391	6,830,820	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,160,531	8.00
9.00	00900	HOUSEKEEPING	0	4,921,263	9.00
10.00	01000	DIETARY	-12,035	3,408,189	10.00
11.00	01100	CAFETERIA	-952,274	1,175,411	11.00
13.00	01300	NURSING ADMINISTRATION	-1,161	2,426,399	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	756,095	14.00
15.00	01500	PHARMACY	0	3,716,164	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,324	2,368,661	16.00
17.00	01700	SOCIAL SERVICE	0	2,997,012	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-904,039	30,417,314	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,985,979	31.00
31.01	02060	NEONATAL NICU	0	6,016,685	31.01
43.00	04300	NURSERY	-41,408	703,638	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,090	6,926,742	50.00
50.01	05001	ENDOSCOPY	-263	1,743,713	50.01
51.00	05100	RECOVERY ROOM	0	1,279,267	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,105,912	52.00
53.00	05300	ANESTHESIOLOGY	-265	279,060	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,076,997	54.00
54.01	03630	ULTRASOUND	0	1,289,647	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	793,484	54.02
54.03	03440	MAMMOGRAPHY	0	1,228,441	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	899,863	55.00
56.00	05600	RADIOISOTOPE	0	561,239	56.00
57.00	05700	CT SCAN	0	1,146,419	57.00
58.00	05800	MRI	0	845,444	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,501,007	59.00
60.00	06000	LABORATORY	-7,061	7,269,518	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	-2,226	1,632,476	63.00
64.00	06400	INTRAVENOUS THERAPY	0	339,420	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,122,508	65.00
66.00	06600	PHYSICAL THERAPY	0	1,390,609	66.00
66.01	06601	REHAB OUTPATIENT	0	1,412,175	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	249,063	67.00
68.00	06800	SPEECH PATHOLOGY	0	130,983	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,112,464	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	242,014	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,508,022	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,758,861	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,576,257	73.00
74.00	07400	RENAL DIALYSIS	0	686,764	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.02	09001	PROCEDURE CLINIC	0	2,777,779	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	-357,881	186,192	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	513,563	90.05
91.00	09100	EMERGENCY	0	9,421,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-21,019,877	296,107,121	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	673,345	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-4,157,834	421,088	192.00
192.01	19201	POB	-7,556,210	35,648	192.01
194.00	07950	COMMUNITY PROGRAMS	0	10,267	194.00
194.01	07951	VACANT SPACE	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-32,733,921	297,247,469	200.00

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-6

Date/Time Prepared:
12/1/2014 2:15 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,825,669	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,573,976	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
TOTALS			0	8,399,645	
B - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	12,508,022	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,916,273	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
TOTALS			0	14,424,295	

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-6

Date/Time Prepared:
12/1/2014 2:15 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	C - RECLASS CHARGEABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,576,257	1.00
	TOTALS		0	11,576,257	
	D - RECLASS DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,287,393	1.00
	TOTALS		0	5,287,393	
	E - RECLASS LAUNDRY COSTS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	1,160,531	1.00
	TOTALS		0	1,160,531	
	F - RECLASS CAFETERIA COSTGS				
1.00	CAFETERIA	11.00	16,658	1,449,153	1.00
	TOTALS		16,658	1,449,153	
	G - RECLASS WORKERS COMPENSATION				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	645,479	1.00
	TOTALS		0	645,479	
	H - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,261,924	1.00
	TOTALS		0	9,261,924	
	I - RECLASS NEGATIVE SALARIES				
1.00	HOUSEKEEPING	9.00	134	0	1.00
	TOTALS		134	0	
500.00	Grand Total: Increases		16,792	52,204,677	500.00

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-6
Date/Time Prepared:
12/1/2014 2:15 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - RECLASS LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,402,920	10	1.00
2.00	OPERATION OF PLANT	7.00	0	20,261	10	2.00
3.00	HOUSEKEEPING	9.00	0	5,486	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	376,532	0	4.00
5.00	PHARMACY	15.00	0	312,783	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	161	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	175,883	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	46,351	0	8.00
9.00	NURSERY	43.00	0	13,554	0	9.00
10.00	OPERATING ROOM	50.00	0	814,515	0	10.00
11.00	ENDOSCOPY	50.01	0	659,636	0	11.00
12.00	RECOVERY ROOM	51.00	0	2,751	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	358	0	13.00
14.00	MAMMOGRAPHY	54.03	0	430,872	0	14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	212,098	0	15.00
16.00	CT SCAN	57.00	0	113,942	0	16.00
17.00	MRI	58.00	0	787,285	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	163,969	0	18.00
19.00	LABORATORY	60.00	0	160,348	0	19.00
20.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	4,279	0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	232,052	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	60	0	22.00
23.00	REHAB OUTPATIENT	66.01	0	288,201	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	0	8,118	0	24.00
25.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,983	0	25.00
26.00	PROCEDURE CLINIC	90.02	0	32,324	0	26.00
27.00	OFFSITE IMAGING CENTER	90.05	0	341,237	0	27.00
28.00	EMERGENCY	91.00	0	8,341	0	28.00
29.00	POB	192.01	0	781,345	0	29.00
TOTALS			0	8,399,645		
B - RECLASS MEDICAL SUPPLIES						
1.00		0.00	0	0	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	644,971	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	301,718	0	3.00
4.00	NEONATAL NICU	31.01	0	167,437	0	4.00
5.00	NURSERY	43.00	0	162	0	5.00
6.00	OPERATING ROOM	50.00	0	5,672,560	0	6.00
7.00	ENDOSCOPY	50.01	0	504,918	0	7.00
8.00	RECOVERY ROOM	51.00	0	48,093	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	409,339	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	181,051	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	51,805	0	11.00
12.00	ULTRASOUND	54.01	0	31,856	0	12.00
13.00	RADIOLOGY-SPECIAL PROCEDURES	54.02	0	399,886	0	13.00
14.00	MAMMOGRAPHY	54.03	0	121,019	0	14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	20,980	0	15.00
16.00	RADIOISOTOPE	56.00	0	803,706	0	16.00
17.00	CT SCAN	57.00	0	228,405	0	17.00
18.00	MRI	58.00	0	127,519	0	18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	1,465,447	0	19.00
20.00	INTRAVENOUS THERAPY	64.00	0	248,351	0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	141,749	0	21.00
22.00	ELECTROCARDIOLOGY	69.00	0	6,951	0	22.00
23.00	PROCEDURE CLINIC	90.02	0	129,513	0	23.00
24.00	OFFSITE IMAGING CENTER	90.05	0	11,225	0	24.00
25.00	EMERGENCY	91.00	0	789,361	0	25.00
26.00	ADMINISTRATIVE & GENERAL	5.00	0	4,273	0	26.00
27.00	CENTRAL SERVICES & SUPPLY	14.00	0	300	0	27.00
28.00	ADULTS & PEDIATRICS	30.00	0	434	0	28.00
29.00	INTENSIVE CARE UNIT	31.00	0	102	0	29.00
30.00	OPERATING ROOM	50.00	0	68,714	0	30.00
31.00	ENDOSCOPY	50.01	0	41,330	0	31.00
32.00	DELIVERY ROOM & LABOR ROOM	52.00	0	12,754	0	32.00
33.00	ANESTHESIOLOGY	53.00	0	210	0	33.00
34.00	RADIOLOGY-SPECIAL PROCEDURES	54.02	0	211,190	0	34.00
35.00	CARDIAC CATHETERIZATION	59.00	0	1,352,546	0	35.00
36.00	PROCEDURE CLINIC	90.02	0	224,420	0	36.00
TOTALS			0	14,424,295		

RECLASSIFICATIONS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-6

Date/Time Prepared:
12/1/2014 2:15 pm

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	C - RECLASS CHARGEABLE DRUGS							
1.00	PHARMACY	15.00	0	11,576,257	0		1.00	
	TOTALS		0	11,576,257				
	D - RECLASS DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,287,393	9		1.00	
	TOTALS		0	5,287,393				
	E - RECLASS LAUNDRY COSTS							
1.00	HOUSEKEEPING	9.00	0	1,160,531	0		1.00	
	TOTALS		0	1,160,531				
	F - RECLASS CAFETERIA COSTGS							
1.00	DIETARY	10.00	16,658	1,449,153	0		1.00	
	TOTALS		16,658	1,449,153				
	G - RECLASS WORKERS COMPENSATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	645,479	0		1.00	
	TOTALS		0	645,479				
	H - RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	9,261,924	11		1.00	
	TOTALS		0	9,261,924				
	I - RECLASS NEGATIVE SALARIES							
1.00	HOUSEKEEPING	9.00	0	134	0		1.00	
	TOTALS		0	134				
500.00	Grand Total: Decreases		16,658	52,204,811			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
12/1/2014 2:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	3.00	4.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	11,220,000	0	0	0	0	1.00
2.00	Land Improvements	14,359	0	0	0	0	2.00
3.00	Buildings and Fixtures	221,279,271	1,528,363	0	1,528,363	0	3.00
4.00	Building Improvements	6,397,421	7,041,030	0	7,041,030	0	4.00
5.00	Fixed Equipment	8,284,945	740,207	0	740,207	0	5.00
6.00	Movable Equipment	29,412,186	5,058,894	0	5,058,894	23,316	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	276,608,182	14,368,494	0	14,368,494	23,316	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	276,608,182	14,368,494	0	14,368,494	23,316	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	11,220,000	0				1.00
2.00	Land Improvements	14,359	0				2.00
3.00	Buildings and Fixtures	222,807,634	0				3.00
4.00	Building Improvements	13,438,451	0				4.00
5.00	Fixed Equipment	9,025,152	0				5.00
6.00	Movable Equipment	34,447,764	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	290,953,360	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	290,953,360	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	14,609,786	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,609,786	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	14,609,786				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	14,609,786				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-7
Part III
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	256,505,596	0	256,505,596	0.881604	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,447,764	0	34,447,764	0.118396	0	2.00
3.00	Total (sum of lines 1-2)	290,953,360	0	290,953,360	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	15,041,024	2,825,669	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,637,765	5,573,976	2.00
3.00	Total (sum of lines 1-2)	0	0	0	18,678,789	8,399,645	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	9,552,954	0	0	0	27,419,647	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-9,262,000	0	0	0	-50,259	2.00
3.00	Total (sum of lines 1-2)	290,954	0	0	0	27,369,388	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8

Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center		Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-9,262,000		CAP REL COSTS-MVBLE EQUIP	2.00		11	2.00
3.00 Investment income - other (chapter 2)	B	-291,030		ADMINISTRATIVE & GENERAL	5.00		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	-1,258,584					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	11,562,601					0	12.00
13.00 Laundry and linen service		0			0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-952,274		CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0			0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00		0	16.00
17.00 Sale of drugs to other than patients		0			0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-16,014		MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00		0	19.00
20.00 Vending machines	B	-12,035		DIETARY	10.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-997,274		CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,649,628		CAP REL COSTS-MVBLE EQUIP	2.00		9	27.00
28.00 Non-physician Anesthetist		0		*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0			0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)		0		ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00		0	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00		0	33.00

Provider CCN: 140290
 Period: From 07/01/2013 To 06/30/2014
 Worksheet A-8
 Date/Time Prepared: 12/1/2014 2:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
34.00 OTHER EDUCATION	B	-1,161	NURSING ADMINISTRATION	13.00	0 34.00
34.01 MISC INCOME	B	-33,136	OPERATION OF PLANT	7.00	0 34.01
34.02 LOBBYING PORTION OF FEES	A	-50,000	ADMINISTRATIVE & GENERAL	5.00	0 34.02
34.03 ALPHA READMIT TEAM	B	-125,447	ADMINISTRATIVE & GENERAL	5.00	0 34.03
34.04 NONPATIENT RELATED INCOME	B	-243,983	ADMINISTRATIVE & GENERAL	5.00	0 34.04
34.05 COMMUNITY TRANSPORT	B	-7,493	ADMINISTRATIVE & GENERAL	5.00	0 34.05
34.06 PERINATAL CLASS TUITION	B	-41,408	NURSERY	43.00	0 34.06
34.07 OTHER MISCELLANEOUS INCOME	B	-352,589	ADMINISTRATIVE & GENERAL	5.00	0 34.07
35.00 BAD DEBT EXPENSE	A	-16,205,139	ADMINISTRATIVE & GENERAL	5.00	0 35.00
36.00 OFFSET INCOME TAXES	A	-98,286	ADMINISTRATIVE & GENERAL	5.00	0 36.00
37.00 OFFSET TAXES	A	-902,039	ADMINISTRATIVE & GENERAL	5.00	0 37.00
38.00 OFFSET INTERCOMPANY INCOME	B	-7,061	LABORATORY	60.00	0 38.00
38.01 OFFSET INTERCOMPANY INCOME	B	-2,226	BLOOD STORING, PROCESSING & TRANS.	63.00	0 38.01
39.00 OFFSET CONTRIBUTIONS	A	-5,055	ADMINISTRATIVE & GENERAL	5.00	0 39.00
40.00 OFFSET LOBBYING DUES AHA	A	-13,415	ADMINISTRATIVE & GENERAL	5.00	0 40.00
41.00 OFFSET LOBBYING DUES MCHC	A	-55,201	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00 OFFSET PHYSICIAN FEES	A	-4,157,834	PHYSICIANS' PRIVATE OFFICES	192.00	0 42.00
43.00 OFFSET PHYSICIAN FEES	A	-7,556,210	POB	192.01	0 43.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,733,921			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: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:
12/1/2014 2:15 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	ABHN NON CAP	46,483,640	41,924,308	1.00
2.00	0.00		0	0	0	2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	77,338	0	3.00
3.01	7.00	OPERATION OF PLANT	PLANT OPERATIONS	4,431,871	4,792,126	3.01
3.02	1.00	CAP REL COSTS-BLDG & FIXT	ABHN CAPITAL	6,715,905	0	3.02
3.03	30.00	ADULTS & PEDIATRICS	ABHN A & P	-4,954	0	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	EXECUTIVE SALARIES	1,433,781	1,198,560	3.04
3.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	EXECUTIVE BENEFITS	224,424	175,440	3.05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	291,030	0	3.06
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			59,653,035	48,090,434	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.

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

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

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

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

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

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

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

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:
12/1/2014 2:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	4,559,332	0		1.00
2.00	0	0		2.00
3.00	77,338	0		3.00
3.01	-360,255	0		3.01
3.02	6,715,905	9		3.02
3.03	-4,954	0		3.03
3.04	235,221	0		3.04
3.05	48,984	0		3.05
3.06	291,030	11		3.06
4.00	0	0		4.00
5.00	11,562,601			5.00

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

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

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

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

6.00			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: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet A-8-2

Date/Time Prepared:
12/1/2014 2:15 pm

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00 ADULTS & PEDIATRICS	899,767	898,567	1,200	177,200	8	1.00
2.00	50.00 OPERATING ROOM	1,490	890	600	208,000	4	2.00
3.00	50.01 ENDOSCOPY	263	263	0	0	0	3.00
4.00	53.00 ANESTHESIOLOGY	650	0	650	200,300	4	4.00
5.00	90.04 EPILEPSY MONITORING UNIT	357,881	357,881	0	0	0	5.00
6.00	0.00	0	0	0	0	0	6.00
7.00	0.00	0	0	0	0	0	7.00
8.00	0.00	0	0	0	0	0	8.00
9.00	0.00	0	0	0	0	0	9.00
10.00	0.00	0	0	0	0	0	10.00
200.00		1,260,051	1,257,601	2,450		16	200.00

Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00 ADULTS & PEDIATRICS	682	34	0	0	0	1.00
2.00	50.00 OPERATING ROOM	400	20	0	0	0	2.00
3.00	50.01 ENDOSCOPY	0	0	0	0	0	3.00
4.00	53.00 ANESTHESIOLOGY	385	19	0	0	0	4.00
5.00	90.04 EPILEPSY MONITORING UNIT	0	0	0	0	0	5.00
6.00	0.00	0	0	0	0	0	6.00
7.00	0.00	0	0	0	0	0	7.00
8.00	0.00	0	0	0	0	0	8.00
9.00	0.00	0	0	0	0	0	9.00
10.00	0.00	0	0	0	0	0	10.00
200.00		1,467	73	0	0	0	200.00

Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00 ADULTS & PEDIATRICS	0	682	518	899,085	1.00
2.00	50.00 OPERATING ROOM	0	400	200	1,090	2.00
3.00	50.01 ENDOSCOPY	0	0	0	263	3.00
4.00	53.00 ANESTHESIOLOGY	0	385	265	265	4.00
5.00	90.04 EPILEPSY MONITORING UNIT	0	0	0	357,881	5.00
6.00	0.00	0	0	0	0	6.00
7.00	0.00	0	0	0	0	7.00
8.00	0.00	0	0	0	0	8.00
9.00	0.00	0	0	0	0	9.00
10.00	0.00	0	0	0	0	10.00
200.00		0	1,467	983	1,258,584	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	27,419,647	27,419,647			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	-50,259		-50,259		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	14,870,659	19,481	0	14,890,140	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	88,975,215	2,229,626	0	1,384,386	5.00
7.00 00700	OPERATION OF PLANT	6,830,820	7,478,785	0	130,301	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,160,531	0	0	0	8.00
9.00 00900	HOUSEKEEPING	4,921,263	314,431	0	0	9.00
10.00 01000	DIETARY	3,408,189	279,537	0	5,948	10.00
11.00 01100	CAFETERIA	1,175,411	202,891	0	2,549	11.00
13.00 01300	NURSING ADMINISTRATION	2,426,399	446,351	0	313,956	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	756,095	140,667	0	67,028	14.00
15.00 01500	PHARMACY	3,716,164	204,168	0	457,188	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,368,661	312,304	0	191,733	16.00
17.00 01700	SOCIAL SERVICE	2,997,012	13,665	0	360,081	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	30,417,314	6,269,100	0	4,111,591	30.00
31.00 03100	INTENSIVE CARE UNIT	4,985,979	510,088	0	665,191	31.00
31.01 02060	NEONATAL NICU	6,016,685	929,724	0	806,865	31.01
43.00 04300	NURSERY	703,638	60,522	0	108,054	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,926,742	1,557,688	0	764,496	50.00
50.01 05001	ENDOSCOPY	1,743,713	501,624	0	219,605	50.01
51.00 05100	RECOVERY ROOM	1,279,267	267,810	0	175,986	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,105,912	708,818	0	544,329	52.00
53.00 05300	ANESTHESIOLOGY	279,060	25,013	0	11,365	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,076,997	695,390	0	410,805	54.00
54.01 03630	ULTRASOUND	1,289,647	53,051	0	177,790	54.01
54.02 05401	RADIOLOGY-SPECIAL PROCEDURES	793,484	48,701	0	106,779	54.02
54.03 03440	MAMMOGRAPHY	1,228,441	232,017	0	157,642	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	899,863	587,632	0	124,746	55.00
56.00 05600	RADIOISOTOPE	561,239	100,571	0	70,792	56.00
57.00 05700	CT SCAN	1,146,419	125,962	0	155,647	57.00
58.00 05800	MRI	845,444	96,930	0	111,462	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,501,007	315,755	0	248,673	59.00
60.00 06000	LABORATORY	7,269,518	636,995	0	390,485	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,632,476	25,675	0	63,535	63.00
64.00 06400	INTRAVENOUS THERAPY	339,420	0	0	38,132	64.00
65.00 06500	RESPIRATORY THERAPY	3,122,508	67,946	0	412,189	65.00
66.00 06600	PHYSICAL THERAPY	1,390,609	50,640	0	190,167	66.00
66.01 06601	REHAB OUTPATIENT	1,412,175	5,627	0	185,680	66.01
67.00 06700	OCCUPATIONAL THERAPY	249,063	202,182	0	35,497	67.00
68.00 06800	SPEECH PATHOLOGY	130,983	0	0	18,677	68.00
69.00 06900	ELECTROCARDIOLOGY	1,112,464	0	0	151,898	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	242,014	26,289	0	32,647	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,508,022	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	12,758,861	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	11,576,257	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	686,764	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001	PROCEDURE CLINIC	2,777,779	301,287	0	380,490	90.02
90.03 09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04 09002	EPILEPSY MONITORING UNIT	186,192	0	0	17,787	90.04
90.05 09003	OFFSITE IMAGING CENTER	513,563	0	0	62,573	90.05
91.00 09100	EMERGENCY	9,421,795	980,648	0	1,005,201	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	296,107,121	27,025,591	0	14,869,946	295,743,130
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	673,345	112,297	0	19,634	805,276
192.00 19200	PHYSICIANS' PRIVATE OFFICES	421,088	0	0	0	421,088
192.01 19201	POB	35,648	0	0	0	35,648
194.00 07950	COMMUNITY PROGRAMS	10,267	0	0	560	10,827
194.01 07951	VACANT SPACE	0	281,759	0	0	281,759
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	-50,259	0	-50,259

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
202.00 TOTAL (sum lines 118-201)	297,247,469	27,419,647	-50,259	14,890,140	297,247,469	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	92,589,227				5.00	
7.00	00700	OPERATION OF PLANT	6,531,141	20,971,047			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	524,906		1,685,437		8.00	
9.00	00900	HOUSEKEEPING	2,368,094	372,713	0	7,976,501	9.00	
10.00	01000	DIETARY	1,670,641	331,351	0	130,427	10.00	
11.00	01100	CAFETERIA	624,556	240,498	0	94,666	11.00	
13.00	01300	NURSING ADMINISTRATION	1,441,341	529,085	0	208,260	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	435,920	166,740	0	65,633	14.00	
15.00	01500	PHARMACY	1,979,944	242,012	0	95,261	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	1,299,316	370,191	0	145,716	16.00	
17.00	01700	SOCIAL SERVICE	1,524,587	16,198	0	6,376	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,452,838	7,431,121	960,339	2,925,056	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,786,725	604,637	84,209	237,998	31.00	
31.01	02060	NEONATAL NICU	3,506,790	1,102,055	14,440	433,793	31.01	
43.00	04300	NURSERY	394,501	71,740	0	28,239	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,183,271	1,846,417	199,373	726,791	50.00	
50.01	05001	ENDOSCOPY	1,114,888	594,604	0	234,049	50.01	
51.00	05100	RECOVERY ROOM	779,338	317,451	0	124,956	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,423,892	840,203	107,632	330,723	52.00	
53.00	05300	ANESTHESIOLOGY	142,672	29,649	0	11,670	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,892,049	824,285	4,146	324,457	54.00	
54.01	03630	ULTRASOUND	687,714	62,885	48,032	24,753	54.01	
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	429,215	57,729	0	22,723	54.02	
54.03	03440	MAMMOGRAPHY	731,863	275,023	0	108,255	54.03	
55.00	05500	RADIOLOGY-THERAPEUTIC	729,213	696,554	12,813	274,179	55.00	
56.00	05600	RADIOISOTOPE	331,354	119,212	0	46,925	56.00	
57.00	05700	CT SCAN	645,894	149,310	58,956	58,772	57.00	
58.00	05800	MRI	476,648	114,897	0	45,226	58.00	
59.00	05900	CARDIAC CATHETERIZATION	934,192	374,283	0	147,326	59.00	
60.00	06000	LABORATORY	3,752,716	755,067	0	297,211	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	778,715	30,434	0	11,979	63.00	
64.00	06400	INTRAVENOUS THERAPY	170,766	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	1,629,468	80,540	0	31,702	65.00	
66.00	06600	PHYSICAL THERAPY	737,886	60,026	0	23,628	66.00	
66.01	06601	REHAB OUTPATIENT	725,252	6,670	0	2,625	66.01	
67.00	06700	OCCUPATIONAL THERAPY	220,152	239,658	0	94,335	67.00	
68.00	06800	SPEECH PATHOLOGY	67,691	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	571,868	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	136,119	31,162	0	12,266	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,657,353	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,770,807	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	5,235,918	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	310,622	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	1,564,750	357,132	0	140,575	90.02	
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03	
90.04	09002	EPILEPSY MONITORING UNIT	92,259	0	0	0	90.04	
90.05	09003	OFFSITE IMAGING CENTER	260,585	0	0	0	90.05	
91.00	09100	EMERGENCY	5,159,655	1,162,418	195,497	457,554	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	91,886,085	20,503,950	1,685,437	7,924,105	5,826,093	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	364,225	133,112	0	52,396	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	190,457	0	0	0	192.00	
192.01	19201	POB	16,124	0	0	0	192.01	
194.00	07950	COMMUNITY PROGRAMS	4,897	0	0	0	194.00	
194.01	07951	VACANT SPACE	127,439	333,985	0	0	194.01	
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)	92,589,227	20,971,047	1,685,437	7,976,501	5,826,093	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part I
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,340,571					11.00
13.00	01300		5,403,456				13.00
14.00	01400	18,186	0	1,650,269			14.00
15.00	01500	70,317	0	0	6,765,054		15.00
16.00	01600	64,524	0	0	0	4,752,445	16.00
17.00	01700	57,378	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	788,940	2,808,231	0	0	522,058	30.00
31.00	03100	104,168	370,785	0	0	71,405	31.00
31.01	02060	104,093	370,517	0	0	101,057	31.01
43.00	04300	15,797	56,230	0	0	29,793	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	119,100	423,936	0	0	413,086	50.00
50.01	05001	38,929	138,567	0	0	180,668	50.01
51.00	05100	25,351	90,236	0	0	78,935	51.00
52.00	05200	85,493	304,313	0	0	84,726	52.00
53.00	05300	3,385	0	0	0	99,214	53.00
54.00	05400	102,964	0	0	0	135,578	54.00
54.01	03630	24,768	0	0	0	103,482	54.01
54.02	05401	14,124	0	0	0	29,963	54.02
54.03	03440	27,250	0	0	0	52,643	54.03
55.00	05500	15,666	0	0	0	67,508	55.00
56.00	05600	9,347	0	0	0	78,549	56.00
57.00	05700	23,621	0	0	0	294,367	57.00
58.00	05800	16,832	0	0	0	151,287	58.00
59.00	05900	26,761	0	0	0	91,850	59.00
60.00	06000	109,114	0	0	0	609,321	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	13,127	0	0	0	28,210	63.00
64.00	06400	5,360	0	0	0	12,560	64.00
65.00	06500	66,988	0	0	0	127,823	65.00
66.00	06600	27,156	0	0	0	36,708	66.00
66.01	06601	32,817	0	0	0	29,598	66.01
67.00	06700	5,679	0	0	0	14,796	67.00
68.00	06800	2,238	0	0	0	3,392	68.00
69.00	06900	28,191	0	0	0	110,924	69.00
70.00	07000	6,864	0	0	0	14,373	70.00
71.00	07100	0	0	816,949	0	254,962	71.00
72.00	07200	0	0	833,320	0	75,647	72.00
73.00	07300	0	0	0	6,765,054	402,505	73.00
74.00	07400	0	0	0	0	10,765	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	44,063	172,372	0	0	43,032	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	6,921	24,634	0	0	2,522	90.04
90.05	09003	11,227	0	0	0	36,894	90.05
91.00	09100	180,822	643,635	0	0	352,244	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,335,625	5,403,456	1,650,269	6,765,054	4,752,445	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	4,758	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	188	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,340,571	5,403,456	1,650,269	6,765,054	4,752,445	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part I Date/Time Prepared: 12/1/2014 2:15 pm
---	--	----------------------	---	---

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	4,975,297			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,587,480	84,646,025	0	84,646,025	30.00
31.00	03100	INTENSIVE CARE UNIT	387,817	11,263,138	0	11,263,138	31.00
31.01	02060	NEONATAL NICU	0	13,386,019	0	13,386,019	31.01
43.00	04300	NURSERY	0	1,468,514	0	1,468,514	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	17,160,900	0	17,160,900	50.00
50.01	05001	ENDOSCOPY	0	4,766,647	0	4,766,647	50.01
51.00	05100	RECOVERY ROOM	0	3,139,330	0	3,139,330	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,536,041	0	9,536,041	52.00
53.00	05300	ANESTHESIOLOGY	0	602,028	0	602,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,466,671	0	7,466,671	54.00
54.01	03630	ULTRASOUND	0	2,472,122	0	2,472,122	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	1,502,718	0	1,502,718	54.02
54.03	03440	MAMMOGRAPHY	0	2,813,134	0	2,813,134	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,408,174	0	3,408,174	55.00
56.00	05600	RADIOISOTOPE	0	1,317,989	0	1,317,989	56.00
57.00	05700	CT SCAN	0	2,658,948	0	2,658,948	57.00
58.00	05800	MRI	0	1,858,726	0	1,858,726	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,639,847	0	3,639,847	59.00
60.00	06000	LABORATORY	0	13,820,427	0	13,820,427	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,584,151	0	2,584,151	63.00
64.00	06400	INTRAVENOUS THERAPY	0	566,238	0	566,238	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,539,164	0	5,539,164	65.00
66.00	06600	PHYSICAL THERAPY	0	2,516,820	0	2,516,820	66.00
66.01	06601	REHAB OUTPATIENT	0	2,400,444	0	2,400,444	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	1,061,362	0	1,061,362	67.00
68.00	06800	SPEECH PATHOLOGY	0	222,981	0	222,981	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,975,345	0	1,975,345	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	501,734	0	501,734	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,237,286	0	19,237,286	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,438,635	0	19,438,635	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,979,734	0	23,979,734	73.00
74.00	07400	RENAL DIALYSIS	0	1,008,151	0	1,008,151	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	PROCEDURE CLINIC	0	5,781,480	0	5,781,480	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	330,315	0	330,315	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	884,842	0	884,842	90.05
91.00	09100	EMERGENCY	0	19,559,469	0	19,559,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,975,297	294,515,549	0	294,515,549	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,359,767	0	1,359,767	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	611,545	0	611,545	192.00
192.01	19201	POB	0	51,772	0	51,772	192.01
194.00	07950	COMMUNITY PROGRAMS	0	15,912	0	15,912	194.00
194.01	07951	VACANT SPACE	0	743,183	0	743,183	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	-50,259	0	-50,259	201.00
202.00		TOTAL (sum lines 118-201)	4,975,297	297,247,469	0	297,247,469	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 12/1/2014 2:15 pm
-------------------------------------	--	----------------------	---	--

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,481	0	19,481	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	2,229,626	0	2,229,626	5.00
7.00 00700	OPERATION OF PLANT	0	7,478,785	0	7,478,785	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	314,431	0	314,431	9.00
10.00 01000	DIETARY	0	279,537	0	279,537	10.00
11.00 01100	CAFETERIA	0	202,891	0	202,891	11.00
13.00 01300	NURSING ADMINISTRATION	0	446,351	0	446,351	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	140,667	0	140,667	14.00
15.00 01500	PHARMACY	0	204,168	0	204,168	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	312,304	0	312,304	16.00
17.00 01700	SOCIAL SERVICE	0	13,665	0	13,665	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	6,269,100	0	6,269,100	30.00
31.00 03100	INTENSIVE CARE UNIT	0	510,088	0	510,088	31.00
31.01 02060	NEONATAL NICU	0	929,724	0	929,724	31.01
43.00 04300	NURSERY	0	60,522	0	60,522	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	1,557,688	0	1,557,688	50.00
50.01 05001	ENDOSCOPY	0	501,624	0	501,624	50.01
51.00 05100	RECOVERY ROOM	0	267,810	0	267,810	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	708,818	0	708,818	52.00
53.00 05300	ANESTHESIOLOGY	0	25,013	0	25,013	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	695,390	0	695,390	54.00
54.01 03630	ULTRASOUND	0	53,051	0	53,051	54.01
54.02 05401	RADIOLOGY-SPECIAL PROCEDURES	0	48,701	0	48,701	54.02
54.03 03440	MAMMOGRAPHY	0	232,017	0	232,017	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	0	587,632	0	587,632	55.00
56.00 05600	RADIOISOTOPE	0	100,571	0	100,571	56.00
57.00 05700	CT SCAN	0	125,962	0	125,962	57.00
58.00 05800	MRI	0	96,930	0	96,930	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	315,755	0	315,755	59.00
60.00 06000	LABORATORY	0	636,995	0	636,995	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	25,675	0	25,675	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	67,946	0	67,946	65.00
66.00 06600	PHYSICAL THERAPY	0	50,640	0	50,640	66.00
66.01 06601	REHAB OUTPATIENT	0	5,627	0	5,627	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	202,182	0	202,182	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	26,289	0	26,289	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001	PROCEDURE CLINIC	0	301,287	0	301,287	90.02
90.03 09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04 09002	EPILEPSY MONITORING UNIT	0	0	0	0	90.04
90.05 09003	OFFSITE IMAGING CENTER	0	0	0	0	90.05
91.00 09100	EMERGENCY	0	980,648	0	980,648	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	27,025,591	0	27,025,591	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	112,297	0	112,297	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	POB	0	0	0	0	192.01
194.00 07950	COMMUNITY PROGRAMS	0	0	0	0	194.00
194.01 07951	VACANT SPACE	0	281,759	0	281,759	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	-50,259	-50,259	201.00
202.00	TOTAL (sum lines 118-201)	0	27,419,647	-50,259	27,369,388	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B
Part II
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,231,435				5.00
7.00	00700	OPERATION OF PLANT	157,409	7,636,364			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,651	0	12,651		8.00
9.00	00900	HOUSEKEEPING	57,074	135,719	0	507,224	9.00
10.00	01000	DIETARY	40,265	120,658	0	8,294	448,762
11.00	01100	CAFETERIA	15,053	87,575	0	6,020	0
13.00	01300	NURSING ADMINISTRATION	34,738	192,660	0	13,243	0
14.00	01400	CENTRAL SERVICES & SUPPLY	10,506	60,717	0	4,174	0
15.00	01500	PHARMACY	47,719	88,126	0	6,058	0
16.00	01600	MEDICAL RECORDS & LIBRARY	31,315	134,801	0	9,266	0
17.00	01700	SOCIAL SERVICE	36,745	5,898	0	405	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	444,647	2,705,956	7,209	186,003	413,782
31.00	03100	INTENSIVE CARE UNIT	67,164	220,171	632	15,134	34,980
31.01	02060	NEONATAL NICU	84,518	401,301	108	27,585	0
43.00	04300	NURSERY	9,508	26,123	0	1,796	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	100,823	672,351	1,496	46,216	0
50.01	05001	ENDOSCOPY	26,870	216,518	0	14,883	0
51.00	05100	RECOVERY ROOM	18,783	115,596	0	7,946	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	58,419	305,950	808	21,031	0
53.00	05300	ANESTHESIOLOGY	3,439	10,796	0	742	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,601	300,154	31	20,632	0
54.01	03630	ULTRASOUND	16,575	22,899	361	1,574	0
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	10,345	21,021	0	1,445	0
54.03	03440	MAMMOGRAPHY	17,639	100,147	0	6,884	0
55.00	05500	RADIOLOGY-THERAPEUTIC	17,575	253,642	96	17,435	0
56.00	05600	RADIOISOTOPE	7,986	43,410	0	2,984	0
57.00	05700	CT SCAN	15,567	54,369	443	3,737	0
58.00	05800	MRI	11,488	41,838	0	2,876	0
59.00	05900	CARDIAC CATHETERIZATION	22,515	136,291	0	9,368	0
60.00	06000	LABORATORY	90,446	274,949	0	18,900	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	18,768	11,082	0	762	0
64.00	06400	INTRAVENOUS THERAPY	4,116	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	39,272	29,328	0	2,016	0
66.00	06600	PHYSICAL THERAPY	17,784	21,858	0	1,502	0
66.01	06601	REHAB OUTPATIENT	17,480	2,429	0	167	0
67.00	06700	OCCUPATIONAL THERAPY	5,306	87,269	0	5,999	0
68.00	06800	SPEECH PATHOLOGY	1,631	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	13,783	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	3,281	11,347	0	780	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	136,350	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	139,084	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	126,193	0	0	0	0
74.00	07400	RENAL DIALYSIS	7,486	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	PROCEDURE CLINIC	37,713	130,046	0	8,939	0
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	0
90.04	09002	EPILEPSY MONITORING UNIT	2,224	0	0	0	0
90.05	09003	OFFSITE IMAGING CENTER	6,280	0	0	0	0
91.00	09100	EMERGENCY	124,355	423,281	1,467	29,096	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,214,489	7,466,276	12,651	503,892	448,762
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,778	48,471	0	3,332	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,590	0	0	0	0
192.01	19201	POB	389	0	0	0	0
194.00	07950	COMMUNITY PROGRAMS	118	0	0	0	0
194.01	07951	VACANT SPACE	3,071	121,617	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,231,435	7,636,364	12,651	507,224	448,762

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet B Part II Date/Time Prepared: 12/1/2014 2:15 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	311,542					11.00
13.00	01300	5,066	692,468				13.00
14.00	01400	2,421	0	218,573			14.00
15.00	01500	9,360	0	0	356,029		15.00
16.00	01600	8,589	0	0	0	496,526	16.00
17.00	01700	7,637	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	105,013	359,881	0	0	54,561	30.00
31.00	03100	13,865	47,517	0	0	7,463	31.00
31.01	02060	13,855	47,483	0	0	10,562	31.01
43.00	04300	2,103	7,206	0	0	3,114	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	15,853	54,329	0	0	43,172	50.00
50.01	05001	5,182	17,758	0	0	18,882	50.01
51.00	05100	3,374	11,564	0	0	8,250	51.00
52.00	05200	11,380	38,999	0	0	8,855	52.00
53.00	05300	451	0	0	0	10,369	53.00
54.00	05400	13,705	0	0	0	14,170	54.00
54.01	03630	3,297	0	0	0	10,815	54.01
54.02	05401	1,880	0	0	0	3,132	54.02
54.03	03440	3,627	0	0	0	5,502	54.03
55.00	05500	2,085	0	0	0	7,055	55.00
56.00	05600	1,244	0	0	0	8,209	56.00
57.00	05700	3,144	0	0	0	30,765	57.00
58.00	05800	2,240	0	0	0	15,811	58.00
59.00	05900	3,562	0	0	0	9,599	59.00
60.00	06000	14,524	0	0	0	63,521	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	1,747	0	0	0	2,948	63.00
64.00	06400	713	0	0	0	1,313	64.00
65.00	06500	8,916	0	0	0	13,359	65.00
66.00	06600	3,615	0	0	0	3,836	66.00
66.01	06601	4,368	0	0	0	3,093	66.01
67.00	06700	756	0	0	0	1,546	67.00
68.00	06800	298	0	0	0	355	68.00
69.00	06900	3,752	0	0	0	11,593	69.00
70.00	07000	914	0	0	0	1,502	70.00
71.00	07100	0	0	108,207	0	26,646	71.00
72.00	07200	0	0	110,366	0	7,906	72.00
73.00	07300	0	0	0	356,029	42,066	73.00
74.00	07400	0	0	0	0	1,125	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	5,865	22,090	0	0	4,497	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	921	3,157	0	0	264	90.04
90.05	09003	1,494	0	0	0	3,856	90.05
91.00	09100	24,068	82,484	0	0	36,814	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		310,884	692,468	218,573	356,029	496,526	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	633	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	25	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		311,542	692,468	218,573	356,029	496,526	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 12/1/2014 2:15 pm		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	64,821			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,768	10,611,312	0	10,611,312
31.00	03100	INTENSIVE CARE UNIT	5,053	922,936	0	922,936
31.01	02060	NEONATAL NICU	0	1,516,191	0	1,516,191
43.00	04300	NURSERY	0	110,513	0	110,513
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,492,927	0	2,492,927
50.01	05001	ENDOSCOPY	0	802,004	0	802,004
51.00	05100	RECOVERY ROOM	0	433,553	0	433,553
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,154,971	0	1,154,971
53.00	05300	ANESTHESIOLOGY	0	50,825	0	50,825
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,090,220	0	1,090,220
54.01	03630	ULTRASOUND	0	108,804	0	108,804
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	86,664	0	86,664
54.03	03440	MAMMOGRAPHY	0	366,022	0	366,022
55.00	05500	RADIOLOGY-THERAPEUTIC	0	885,683	0	885,683
56.00	05600	RADIOISOTOPE	0	164,497	0	164,497
57.00	05700	CT SCAN	0	234,190	0	234,190
58.00	05800	MRI	0	171,329	0	171,329
59.00	05900	CARDIAC CATHETERIZATION	0	497,415	0	497,415
60.00	06000	LABORATORY	0	1,099,845	0	1,099,845
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	61,065	0	61,065
64.00	06400	INTRAVENOUS THERAPY	0	6,192	0	6,192
65.00	06500	RESPIRATORY THERAPY	0	161,376	0	161,376
66.00	06600	PHYSICAL THERAPY	0	99,484	0	99,484
66.01	06601	REHAB OUTPATIENT	0	33,407	0	33,407
67.00	06700	OCCUPATIONAL THERAPY	0	303,104	0	303,104
68.00	06800	SPEECH PATHOLOGY	0	2,308	0	2,308
69.00	06900	ELECTROCARDIOLOGY	0	29,327	0	29,327
70.00	07000	ELECTROENCEPHALOGRAPHY	0	44,156	0	44,156
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	271,203	0	271,203
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	257,356	0	257,356
73.00	07300	DRUGS CHARGED TO PATIENTS	0	524,288	0	524,288
74.00	07400	RENAL DIALYSIS	0	8,611	0	8,611
76.97	07697	CARDIAC REHABILITATION	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.02	09001	PROCEDURE CLINIC	0	510,934	0	510,934
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0
90.04	09002	EPILEPSY MONITORING UNIT	0	6,589	0	6,589
90.05	09003	OFFSITE IMAGING CENTER	0	11,712	0	11,712
91.00	09100	EMERGENCY	0	1,703,527	0	1,703,527
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	64,821	26,834,540	0	26,834,540
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	173,537	0	173,537
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,590	0	4,590
192.01	19201	POB	0	389	0	389
194.00	07950	COMMUNITY PROGRAMS	0	144	0	144
194.01	07951	VACANT SPACE	0	406,447	0	406,447
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	-50,259	0	-50,259
202.00		TOTAL (sum lines 118-201)	64,821	27,369,388	0	27,369,388

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	579,906				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		573,947			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	412	412	97,308,835		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	47,155	47,155	9,047,150	-92,589,227	5.00
7.00 00700	OPERATION OF PLANT	158,171	158,171	851,538	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	6,650	6,650	0	0	9.00
10.00 01000	DIETARY	5,912	5,912	38,868	0	10.00
11.00 01100	CAFETERIA	4,291	4,291	16,658	0	11.00
13.00 01300	NURSING ADMINISTRATION	9,440	9,440	2,051,742	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,975	2,975	438,035	0	14.00
15.00 01500	PHARMACY	4,318	4,318	2,987,787	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,605	6,605	1,253,004	0	16.00
17.00 01700	SOCIAL SERVICE	289	289	2,353,178	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	132,587	132,587	26,869,561	0	30.00
31.00 03100	INTENSIVE CARE UNIT	10,788	10,788	4,347,112	0	31.00
31.01 02060	NEONATAL NICU	19,663	19,663	5,272,971	0	31.01
43.00 04300	NURSERY	1,280	1,280	706,146	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,944	32,944	4,996,087	0	50.00
50.01 05001	ENDOSCOPY	10,609	10,609	1,435,150	0	50.01
51.00 05100	RECOVERY ROOM	5,664	5,664	1,150,090	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	14,991	14,991	3,557,263	0	52.00
53.00 05300	ANESTHESIOLOGY	529	529	74,269	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,707	14,707	2,684,669	0	54.00
54.01 03630	ULTRASOUND	1,122	1,122	1,161,882	0	54.01
54.02 05401	RADIOLOGY-SPECIAL PROCEDURES	1,030	1,030	697,817	0	54.02
54.03 03440	MAMMOGRAPHY	4,907	4,907	1,030,211	0	54.03
55.00 05500	RADIOLOGY-THERAPEUTIC	12,428	12,428	815,235	0	55.00
56.00 05600	RADIOISOTOPE	2,127	2,127	462,633	0	56.00
57.00 05700	CT SCAN	2,664	2,664	1,017,174	0	57.00
58.00 05800	MRI	2,050	2,050	728,420	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	6,678	6,678	1,625,110	0	59.00
60.00 06000	LABORATORY	13,472	13,472	2,551,875	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	543	543	415,207	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	249,196	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,437	1,437	2,693,713	0	65.00
66.00 06600	PHYSICAL THERAPY	1,071	1,071	1,242,768	0	66.00
66.01 06601	REHAB OUTPATIENT	119	119	1,213,443	0	66.01
67.00 06700	OCCUPATIONAL THERAPY	4,276	4,276	231,978	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	122,056	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	992,675	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	556	556	213,351	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001	PROCEDURE CLINIC	6,372	6,372	2,486,556	0	90.02
90.03 09004	IMMEDIATE CARE CENTER	0	0	0	0	90.03
90.04 09002	EPILEPSY MONITORING UNIT	0	0	116,242	0	90.04
90.05 09003	OFFSITE IMAGING CENTER	0	0	408,924	0	90.05
91.00 09100	EMERGENCY	20,740	20,740	6,569,123	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	571,572	571,572	97,176,867	-92,589,227	203,153,903
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,375	2,375	128,309	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	POB	0	0	0	0	192.01
194.00 07950	COMMUNITY PROGRAMS	0	0	3,659	0	194.00
194.01 07951	VACANT SPACE	5,959	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					4.00
202.00	Cost to be allocated (per Wkst. B, Part I)	27,419,647	-50,259	14,890,140		92,589,227	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	47.282917	0.000000	0.153019		0.452298	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			19,481		2,231,435	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000200		0.010901	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	374,168				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,119,428			8.00	
9.00	00900	HOUSEKEEPING	6,650	0	361,559		9.00	
10.00	01000	DIETARY	5,912	0	5,912	63,157	10.00	
11.00	01100	CAFETERIA	4,291	0	4,291	0	11.00	
13.00	01300	NURSING ADMINISTRATION	9,440	0	9,440	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	2,975	0	2,975	0	14.00	
15.00	01500	PHARMACY	4,318	0	4,318	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	6,605	0	6,605	0	16.00	
17.00	01700	SOCIAL SERVICE	289	0	289	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	132,587	1,207,622	132,587	58,234	41,951	30.00
31.00	03100	INTENSIVE CARE UNIT	10,788	105,892	10,788	4,923	5,539	31.00
31.01	02060	NEONATAL NICU	19,663	18,158	19,663	0	5,535	31.01
43.00	04300	NURSERY	1,280	0	1,280	0	840	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,944	250,710	32,944	0	6,333	50.00
50.01	05001	ENDOSCOPY	10,609	0	10,609	0	2,070	50.01
51.00	05100	RECOVERY ROOM	5,664	0	5,664	0	1,348	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,991	135,347	14,991	0	4,546	52.00
53.00	05300	ANESTHESIOLOGY	529	0	529	0	180	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,707	5,214	14,707	0	5,475	54.00
54.01	03630	ULTRASOUND	1,122	60,400	1,122	0	1,317	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	1,030	0	1,030	0	751	54.02
54.03	03440	MAMMOGRAPHY	4,907	0	4,907	0	1,449	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	12,428	16,112	12,428	0	833	55.00
56.00	05600	RADIOISOTOPE	2,127	0	2,127	0	497	56.00
57.00	05700	CT SCAN	2,664	74,137	2,664	0	1,256	57.00
58.00	05800	MRI	2,050	0	2,050	0	895	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,678	0	6,678	0	1,423	59.00
60.00	06000	LABORATORY	13,472	0	13,472	0	5,802	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	543	0	543	0	698	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	285	64.00
65.00	06500	RESPIRATORY THERAPY	1,437	0	1,437	0	3,562	65.00
66.00	06600	PHYSICAL THERAPY	1,071	0	1,071	0	1,444	66.00
66.01	06601	REHAB OUTPATIENT	119	0	119	0	1,745	66.01
67.00	06700	OCCUPATIONAL THERAPY	4,276	0	4,276	0	302	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	119	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,499	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	556	0	556	0	365	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	6,372	0	6,372	0	2,343	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	0	0	0	368	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	0	597	90.05
91.00	09100	EMERGENCY	20,740	245,836	20,740	0	9,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	365,834	2,119,428	359,184	63,157	124,194	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,375	0	2,375	0	253	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	POB	0	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	10	194.00
194.01	07951	VACANT SPACE	5,959	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	20,971,047	1,685,437	7,976,501	5,826,093	2,340,571	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56.047142	0.795232	22.061409	92.247779	18.806262	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	7,636,364	12,651	507,224	448,762	311,542	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	20.408918	0.005969	1.402880	7.105499	2.503210	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	80,720					13.00
14.00	01400	0	25,266,883				14.00
15.00	01500	0	0	11,576,257			15.00
16.00	01600	0	0	0	1,356,945,714		16.00
17.00	01700	0	0	0	0	63,157	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	41,951	0	0	149,074,175	58,234	30.00
31.00	03100	5,539	0	0	20,389,644	4,923	31.00
31.01	02060	5,535	0	0	28,857,006	0	31.01
43.00	04300	840	0	0	8,507,537	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,333	0	0	117,957,051	0	50.00
50.01	05001	2,070	0	0	51,590,056	0	50.01
51.00	05100	1,348	0	0	22,540,042	0	51.00
52.00	05200	4,546	0	0	24,193,506	0	52.00
53.00	05300	0	0	0	28,330,618	0	53.00
54.00	05400	0	0	0	38,714,571	0	54.00
54.01	03630	0	0	0	29,549,354	0	54.01
54.02	05401	0	0	0	8,556,041	0	54.02
54.03	03440	0	0	0	15,032,177	0	54.03
55.00	05500	0	0	0	19,277,094	0	55.00
56.00	05600	0	0	0	22,429,783	0	56.00
57.00	05700	0	0	0	84,056,829	0	57.00
58.00	05800	0	0	0	43,200,038	0	58.00
59.00	05900	0	0	0	26,227,919	0	59.00
60.00	06000	0	0	0	173,871,479	0	60.00
62.30	06250	0	0	0	0	0	62.30
63.00	06300	0	0	0	8,055,520	0	63.00
64.00	06400	0	0	0	3,586,584	0	64.00
65.00	06500	0	0	0	36,500,065	0	65.00
66.00	06600	0	0	0	10,481,953	0	66.00
66.01	06601	0	0	0	8,451,847	0	66.01
67.00	06700	0	0	0	4,225,088	0	67.00
68.00	06800	0	0	0	968,582	0	68.00
69.00	06900	0	0	0	31,674,426	0	69.00
70.00	07000	0	0	0	4,104,238	0	70.00
71.00	07100	0	12,508,022	0	72,804,541	0	71.00
72.00	07200	0	12,758,861	0	21,601,116	0	72.00
73.00	07300	0	0	11,576,257	114,935,755	0	73.00
74.00	07400	0	0	0	3,073,954	0	74.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001	2,575	0	0	12,287,964	0	90.02
90.03	09004	0	0	0	0	0	90.03
90.04	09002	368	0	0	720,236	0	90.04
90.05	09003	0	0	0	10,535,260	0	90.05
91.00	09100	9,615	0	0	100,583,665	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		80,720	25,266,883	11,576,257	1,356,945,714	63,157	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		5,403,456	1,650,269	6,765,054	4,752,445	4,975,297	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet B-1

Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	66.940733	0.065314	0.584390	0.003502	78.776652	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	692,468	218,573	356,029	496,526	64,821	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	8.578642	0.008651	0.030755	0.000366	1.026347	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 12/1/2014 2:15 pm
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		84,646,025	518	84,646,543
31.00	03100 INTENSIVE CARE UNIT		11,263,138	0	11,263,138
31.01	02060 NEONATAL NICU		13,386,019	0	13,386,019
43.00	04300 NURSERY		1,468,514	0	1,468,514
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		17,160,900	200	17,161,100
50.01	05001 ENDOSCOPY		4,766,647	0	4,766,647
51.00	05100 RECOVERY ROOM		3,139,330	0	3,139,330
52.00	05200 DELIVERY ROOM & LABOR ROOM		9,536,041	0	9,536,041
53.00	05300 ANESTHESIOLOGY		602,028	265	602,293
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,466,671	0	7,466,671
54.01	03630 ULTRASOUND		2,472,122	0	2,472,122
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES		1,502,718	0	1,502,718
54.03	03440 MAMMOGRAPHY		2,813,134	0	2,813,134
55.00	05500 RADIOLOGY-THERAPEUTIC		3,408,174	0	3,408,174
56.00	05600 RADIOISOTOPE		1,317,989	0	1,317,989
57.00	05700 CT SCAN		2,658,948	0	2,658,948
58.00	05800 MRI		1,858,726	0	1,858,726
59.00	05900 CARDIAC CATHETERIZATION		3,639,847	0	3,639,847
60.00	06000 LABORATORY		13,820,427	0	13,820,427
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		2,584,151	0	2,584,151
64.00	06400 INTRAVENOUS THERAPY		566,238	0	566,238
65.00	06500 RESPIRATORY THERAPY	0	5,539,164	0	5,539,164
66.00	06600 PHYSICAL THERAPY	0	2,516,820	0	2,516,820
66.01	06601 REHAB OUTPATIENT	0	2,400,444	0	2,400,444
67.00	06700 OCCUPATIONAL THERAPY	0	1,061,362	0	1,061,362
68.00	06800 SPEECH PATHOLOGY	0	222,981	0	222,981
69.00	06900 ELECTROCARDIOLOGY		1,975,345	0	1,975,345
70.00	07000 ELECTROENCEPHALOGRAPHY		501,734	0	501,734
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		19,237,286	0	19,237,286
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		19,438,635	0	19,438,635
73.00	07300 DRUGS CHARGED TO PATIENTS		23,979,734	0	23,979,734
74.00	07400 RENAL DIALYSIS		1,008,151	0	1,008,151
76.97	07697 CARDIAC REHABILITATION		0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.02	09001 PROCEDURE CLINIC		5,781,480	0	5,781,480
90.03	09004 IMMEDIATE CARE CENTER		0	0	0
90.04	09002 EPILEPSY MONITORING UNIT		330,315	0	330,315
90.05	09003 OFFSITE IMAGING CENTER		884,842	0	884,842
91.00	09100 EMERGENCY		19,559,469	0	19,559,469
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		10,656,271	0	10,656,271
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
200.00	Subtotal (see instructions)		305,171,820	983	305,172,803
201.00	Less Observation Beds		10,656,271		10,656,271
202.00	Total (see instructions)		294,515,549	983	294,516,532

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet C Part I Date/Time Prepared: 12/1/2014 2:15 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	136,843,221		136,843,221			30.00
31.00	03100	INTENSIVE CARE UNIT	20,389,644		20,389,644			31.00
31.01	02060	NEONATAL NICU	28,857,006		28,857,006			31.01
43.00	04300	NURSERY	8,507,537		8,507,537			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	49,235,902	68,721,149	117,957,051	0.145484	0.000000	50.00
50.01	05001	ENDOSCOPY	10,289,329	41,300,727	51,590,056	0.092395	0.000000	50.01
51.00	05100	RECOVERY ROOM	9,505,052	13,034,990	22,540,042	0.139278	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,988,852	204,654	24,193,506	0.394157	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,301,274	17,029,344	28,330,618	0.021250	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,585,073	27,129,498	38,714,571	0.192865	0.000000	54.00
54.01	03630	ULTRASOUND	7,359,475	22,189,879	29,549,354	0.083661	0.000000	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	4,686,802	3,869,239	8,556,041	0.175632	0.000000	54.02
54.03	03440	MAMMOGRAPHY	8,473	15,023,704	15,032,177	0.187141	0.000000	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	563,664	18,713,430	19,277,094	0.176799	0.000000	55.00
56.00	05600	RADIOISOTOPE	7,023,651	15,406,132	22,429,783	0.058761	0.000000	56.00
57.00	05700	CT SCAN	23,508,657	60,548,172	84,056,829	0.031633	0.000000	57.00
58.00	05800	MRI	10,769,687	32,430,351	43,200,038	0.043026	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,354,524	9,873,395	26,227,919	0.138778	0.000000	59.00
60.00	06000	LABORATORY	79,035,501	94,835,978	173,871,479	0.079486	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,007,326	2,048,194	8,055,520	0.320793	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,220,710	365,874	3,586,584	0.157877	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	33,170,421	3,329,644	36,500,065	0.151758	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,931,402	550,551	10,481,953	0.240110	0.000000	66.00
66.01	06601	REHAB OUTPATIENT	4,181	8,447,666	8,451,847	0.284014	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,956,513	268,575	4,225,088	0.251205	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	920,531	48,051	968,582	0.230214	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,583,944	18,090,482	31,674,426	0.062364	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	919,000	3,185,238	4,104,238	0.122248	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,151,701	29,652,840	72,804,541	0.264232	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,189,693	7,411,423	21,601,116	0.899890	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,686,814	42,248,941	114,935,755	0.208636	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,955,899	118,055	3,073,954	0.327966	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	223,145	12,064,819	12,287,964	0.470499	0.000000	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	720,236	720,236	0.458621	0.000000	90.04
90.05	09003	OFFSITE IMAGING CENTER	51,794	10,483,466	10,535,260	0.083989	0.000000	90.05
91.00	09100	EMERGENCY	24,611,319	75,972,346	100,583,665	0.194460	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,230,954	12,230,954	0.871254	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	689,397,717	667,547,997	1,356,945,714			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	689,397,717	667,547,997	1,356,945,714			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 12/1/2014 2:15 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL NICU			31.01
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.145486		50.00
50.01	05001 ENDOSCOPY	0.092395		50.01
51.00	05100 RECOVERY ROOM	0.139278		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.394157		52.00
53.00	05300 ANESTHESIOLOGY	0.021259		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.192865		54.00
54.01	03630 ULTRASOUND	0.083661		54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0.175632		54.02
54.03	03440 MAMMOGRAPHY	0.187141		54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.176799		55.00
56.00	05600 RADIOISOTOPE	0.058761		56.00
57.00	05700 CT SCAN	0.031633		57.00
58.00	05800 MRI	0.043026		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.138778		59.00
60.00	06000 LABORATORY	0.079486		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.320793		63.00
64.00	06400 INTRAVENOUS THERAPY	0.157877		64.00
65.00	06500 RESPIRATORY THERAPY	0.151758		65.00
66.00	06600 PHYSICAL THERAPY	0.240110		66.00
66.01	06601 REHAB OUTPATIENT	0.284014		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.251205		67.00
68.00	06800 SPEECH PATHOLOGY	0.230214		68.00
69.00	06900 ELECTROCARDIOLOGY	0.062364		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.122248		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.264232		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.899890		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.208636		73.00
74.00	07400 RENAL DIALYSIS	0.327966		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.02	09001 PROCEDURE CLINIC	0.470499		90.02
90.03	09004 IMMEDIATE CARE CENTER	0.000000		90.03
90.04	09002 EPILEPSY MONITORING UNIT	0.458621		90.04
90.05	09003 OFFSITE IMAGING CENTER	0.083989		90.05
91.00	09100 EMERGENCY	0.194460		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.871254		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 12/1/2014 2:15 pm	
			Title XIX	Hospital	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		84,646,025	518	84,646,543	30.00
31.00	03100 INTENSIVE CARE UNIT		11,263,138	0	11,263,138	31.00
31.01	02060 NEONATAL NICU		13,386,019	0	13,386,019	31.01
43.00	04300 NURSERY		1,468,514	0	1,468,514	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		17,160,900	200	17,161,100	50.00
50.01	05001 ENDOSCOPY		4,766,647	0	4,766,647	50.01
51.00	05100 RECOVERY ROOM		3,139,330	0	3,139,330	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		9,536,041	0	9,536,041	52.00
53.00	05300 ANESTHESIOLOGY		602,028	265	602,293	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,466,671	0	7,466,671	54.00
54.01	03630 ULTRASOUND		2,472,122	0	2,472,122	54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES		1,502,718	0	1,502,718	54.02
54.03	03440 MAMMOGRAPHY		2,813,134	0	2,813,134	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC		3,408,174	0	3,408,174	55.00
56.00	05600 RADIOISOTOPE		1,317,989	0	1,317,989	56.00
57.00	05700 CT SCAN		2,658,948	0	2,658,948	57.00
58.00	05800 MRI		1,858,726	0	1,858,726	58.00
59.00	05900 CARDIAC CATHETERIZATION		3,639,847	0	3,639,847	59.00
60.00	06000 LABORATORY		13,820,427	0	13,820,427	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		2,584,151	0	2,584,151	63.00
64.00	06400 INTRAVENOUS THERAPY		566,238	0	566,238	64.00
65.00	06500 RESPIRATORY THERAPY	0	5,539,164	0	5,539,164	65.00
66.00	06600 PHYSICAL THERAPY	0	2,516,820	0	2,516,820	66.00
66.01	06601 REHAB OUTPATIENT	0	2,400,444	0	2,400,444	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	1,061,362	0	1,061,362	67.00
68.00	06800 SPEECH PATHOLOGY	0	222,981	0	222,981	68.00
69.00	06900 ELECTROCARDIOLOGY		1,975,345	0	1,975,345	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		501,734	0	501,734	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		19,237,286	0	19,237,286	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		19,438,635	0	19,438,635	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		23,979,734	0	23,979,734	73.00
74.00	07400 RENAL DIALYSIS		1,008,151	0	1,008,151	74.00
76.97	07697 CARDIAC REHABILITATION		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02	09001 PROCEDURE CLINIC		5,781,480	0	5,781,480	90.02
90.03	09004 IMMEDIATE CARE CENTER		0	0	0	90.03
90.04	09002 EPILEPSY MONITORING UNIT		330,315	0	330,315	90.04
90.05	09003 OFFSITE IMAGING CENTER		884,842	0	884,842	90.05
91.00	09100 EMERGENCY		19,559,469	0	19,559,469	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		10,656,271	0	10,656,271	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		305,171,820	983	305,172,803	200.00
201.00	Less Observation Beds		10,656,271		10,656,271	201.00
202.00	Total (see instructions)		294,515,549	983	294,516,532	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet C Part I Date/Time Prepared: 12/1/2014 2:15 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	136,843,221		136,843,221			30.00
31.00	03100	INTENSIVE CARE UNIT	20,389,644		20,389,644			31.00
31.01	02060	NEONATAL NICU	28,857,006		28,857,006			31.01
43.00	04300	NURSERY	8,507,537		8,507,537			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	49,235,902	68,721,149	117,957,051	0.145484	0.000000	50.00
50.01	05001	ENDOSCOPY	10,289,329	41,300,727	51,590,056	0.092395	0.000000	50.01
51.00	05100	RECOVERY ROOM	9,505,052	13,034,990	22,540,042	0.139278	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,988,852	204,654	24,193,506	0.394157	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,301,274	17,029,344	28,330,618	0.021250	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,585,073	27,129,498	38,714,571	0.192865	0.000000	54.00
54.01	03630	ULTRASOUND	7,359,475	22,189,879	29,549,354	0.083661	0.000000	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	4,686,802	3,869,239	8,556,041	0.175632	0.000000	54.02
54.03	03440	MAMMOGRAPHY	8,473	15,023,704	15,032,177	0.187141	0.000000	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	563,664	18,713,430	19,277,094	0.176799	0.000000	55.00
56.00	05600	RADIOISOTOPE	7,023,651	15,406,132	22,429,783	0.058761	0.000000	56.00
57.00	05700	CT SCAN	23,508,657	60,548,172	84,056,829	0.031633	0.000000	57.00
58.00	05800	MRI	10,769,687	32,430,351	43,200,038	0.043026	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,354,524	9,873,395	26,227,919	0.138778	0.000000	59.00
60.00	06000	LABORATORY	79,035,501	94,835,978	173,871,479	0.079486	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,007,326	2,048,194	8,055,520	0.320793	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,220,710	365,874	3,586,584	0.157877	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	33,170,421	3,329,644	36,500,065	0.151758	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,931,402	550,551	10,481,953	0.240110	0.000000	66.00
66.01	06601	REHAB OUTPATIENT	4,181	8,447,666	8,451,847	0.284014	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	3,956,513	268,575	4,225,088	0.251205	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	920,531	48,051	968,582	0.230214	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,583,944	18,090,482	31,674,426	0.062364	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	919,000	3,185,238	4,104,238	0.122248	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,151,701	29,652,840	72,804,541	0.264232	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,189,693	7,411,423	21,601,116	0.899890	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,686,814	42,248,941	114,935,755	0.208636	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,955,899	118,055	3,073,954	0.327966	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	223,145	12,064,819	12,287,964	0.470499	0.000000	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0.000000	0.000000	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	720,236	720,236	0.458621	0.000000	90.04
90.05	09003	OFFSITE IMAGING CENTER	51,794	10,483,466	10,535,260	0.083989	0.000000	90.05
91.00	09100	EMERGENCY	24,611,319	75,972,346	100,583,665	0.194460	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,230,954	12,230,954	0.871254	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	689,397,717	667,547,997	1,356,945,714			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	689,397,717	667,547,997	1,356,945,714			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 12/1/2014 2:15 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL NICU			31.01
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	05001 ENDOSCOPY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630 ULTRASOUND	0.000000		54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0.000000		54.02
54.03	03440 MAMMOGRAPHY	0.000000		54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
66.01	06601 REHAB OUTPATIENT	0.000000		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.02	09001 PROCEDURE CLINIC	0.000000		90.02
90.03	09004 IMMEDIATE CARE CENTER	0.000000		90.03
90.04	09002 EPILEPSY MONITORING UNIT	0.000000		90.04
90.05	09003 OFFSITE IMAGING CENTER	0.000000		90.05
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part I Date/Time Prepared: 12/1/2014 2:15 pm	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	10,611,312	0	10,611,312	66,621	159.28	30.00
31.00	INTENSIVE CARE UNIT	922,936		922,936	4,923	187.47	31.00
31.01	NEONATAL NICU	1,516,191		1,516,191	3,027	500.89	31.01
43.00	NURSERY	110,513		110,513	10,248	10.78	43.00
200.00	Total (Lines 30-199)	13,160,952		13,160,952	84,819		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	25,474	4,057,499				
31.00	INTENSIVE CARE UNIT	2,468	462,676				
31.01	NEONATAL NICU	0	0				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	27,942	4,520,175				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Prepared: 12/1/2014 2:15 pm
--	--	----------------------	---	--

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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,492,927	117,957,051	0.021134	18,548,636	392,007	50.00
50.01	05001 ENDOSCOPY	802,004	51,590,056	0.015546	5,755,319	89,472	50.01
51.00	05100 RECOVERY ROOM	433,553	22,540,042	0.019235	3,621,439	69,658	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,154,971	24,193,506	0.047739	71,811	3,428	52.00
53.00	05300 ANESTHESIOLOGY	50,825	28,330,618	0.001794	4,190,958	7,519	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,090,220	38,714,571	0.028160	6,271,297	176,600	54.00
54.01	03630 ULTRASOUND	108,804	29,549,354	0.003682	4,037,208	14,865	54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	86,664	8,556,041	0.010129	2,247,704	22,767	54.02
54.03	03440 MAMMOGRAPHY	366,022	15,032,177	0.024349	1,981	48	54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	885,683	19,277,094	0.045945	382,192	17,560	55.00
56.00	05600 RADIOISOTOPE	164,497	22,429,783	0.007334	4,311,330	31,619	56.00
57.00	05700 CT SCAN	234,190	84,056,829	0.002786	12,257,807	34,150	57.00
58.00	05800 MRI	171,329	43,200,038	0.003966	5,106,804	20,254	58.00
59.00	05900 CARDIAC CATHETERIZATION	497,415	26,227,919	0.018965	6,905,246	130,958	59.00
60.00	06000 LABORATORY	1,099,845	173,871,479	0.006326	37,048,191	234,367	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	61,065	8,055,520	0.007581	1,991,610	15,098	63.00
64.00	06400 INTRAVENOUS THERAPY	6,192	3,586,584	0.001726	1,894,510	3,270	64.00
65.00	06500 RESPIRATORY THERAPY	161,376	36,500,065	0.004421	22,395,469	99,010	65.00
66.00	06600 PHYSICAL THERAPY	99,484	10,481,953	0.009491	6,035,170	57,280	66.00
66.01	06601 REHAB OUTPATIENT	33,407	8,451,847	0.003953	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	303,104	4,225,088	0.071739	2,397,182	171,971	67.00
68.00	06800 SPEECH PATHOLOGY	2,308	968,582	0.002383	695,076	1,656	68.00
69.00	06900 ELECTROCARDIOLOGY	29,327	31,674,426	0.000926	7,635,132	7,070	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	44,156	4,104,238	0.010759	458,071	4,928	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	271,203	72,804,541	0.003725	9,161,097	34,125	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	257,356	21,601,116	0.011914	7,642,322	91,051	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	524,288	114,935,755	0.004562	31,698,697	144,609	73.00
74.00	07400 RENAL DIALYSIS	8,611	3,073,954	0.002801	2,203,725	6,173	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.02	09001 PROCEDURE CLINIC	510,934	12,287,964	0.041580	116,960	4,863	90.02
90.03	09004 IMMEDIATE CARE CENTER	0	0	0.000000	0	0	90.03
90.04	09002 EPILEPSY MONITORING UNIT	6,589	720,236	0.009148	0	0	90.04
90.05	09003 OFFSITE IMAGING CENTER	11,712	10,535,260	0.001112	3,724	4	90.05
91.00	09100 EMERGENCY	1,703,527	100,583,665	0.016936	12,433,177	210,568	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,335,870	12,230,954	0.109220	0	0	92.00
200.00	Total (lines 50-199)	15,009,458	1,162,348,306		217,519,845	2,096,948	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part III Date/Time Prepared: 12/1/2014 2:15 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	02060	NEONATAL NICU	0	0	0	0	0	31.01
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	66,621	0.00	25,474	0		30.00
31.00	03100	INTENSIVE CARE UNIT	4,923	0.00	2,468	0		31.00
31.01	02060	NEONATAL NICU	3,027	0.00	0	0		31.01
43.00	04300	NURSERY	10,248	0.00	0	0		43.00
200.00		Total (lines 30-199)	84,819		27,942	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 12/1/2014 2:15 pm
--	----------------------	---	--

Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00	
50.01	05001	ENDOSCOPY	0	0	0	0	0 50.01	
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00	
54.01	03630	ULTRASOUND	0	0	0	0	0 54.01	
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	0 54.02	
54.03	03440	MAMMOGRAPHY	0	0	0	0	0 54.03	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00	
57.00	05700	CT SCAN	0	0	0	0	0 57.00	
58.00	05800	MRI	0	0	0	0	0 58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00	
60.00	06000	LABORATORY	0	0	0	0	0 60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00	
66.01	06601	REHAB OUTPATIENT	0	0	0	0	0 66.01	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0 74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97	
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	0	0	0	0	0 90.02	
90.03	09004	IMMEDIATE CARE CENTER	0	0	0	0	0 90.03	
90.04	09002	EPILEPSY MONITORING UNIT	0	0	0	0	0 90.04	
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	0	0 90.05	
91.00	09100	EMERGENCY	0	0	0	0	0 91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00	
200.00		Total (Lines 50-199)	0	0	0	0	0 200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 12/1/2014 2:15 pm
--	----------------------	---------------------------------------	---

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)	Hospital		Inpatient Program Charges	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	117,957,051	0.000000	0.000000	18,548,636	50.00
50.01	05001	ENDOSCOPY	0	51,590,056	0.000000	0.000000	5,755,319	50.01
51.00	05100	RECOVERY ROOM	0	22,540,042	0.000000	0.000000	3,621,439	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,193,506	0.000000	0.000000	71,811	52.00
53.00	05300	ANESTHESIOLOGY	0	28,330,618	0.000000	0.000000	4,190,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,714,571	0.000000	0.000000	6,271,297	54.00
54.01	03630	ULTRASOUND	0	29,549,354	0.000000	0.000000	4,037,208	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	8,556,041	0.000000	0.000000	2,247,704	54.02
54.03	03440	MAMMOGRAPHY	0	15,032,177	0.000000	0.000000	1,981	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	19,277,094	0.000000	0.000000	382,192	55.00
56.00	05600	RADIOISOTOPE	0	22,429,783	0.000000	0.000000	4,311,330	56.00
57.00	05700	CT SCAN	0	84,056,829	0.000000	0.000000	12,257,807	57.00
58.00	05800	MRI	0	43,200,038	0.000000	0.000000	5,106,804	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,227,919	0.000000	0.000000	6,905,246	59.00
60.00	06000	LABORATORY	0	173,871,479	0.000000	0.000000	37,048,191	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,055,520	0.000000	0.000000	1,991,610	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,586,584	0.000000	0.000000	1,894,510	64.00
65.00	06500	RESPIRATORY THERAPY	0	36,500,065	0.000000	0.000000	22,395,469	65.00
66.00	06600	PHYSICAL THERAPY	0	10,481,953	0.000000	0.000000	6,035,170	66.00
66.01	06601	REHAB OUTPATIENT	0	8,451,847	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	4,225,088	0.000000	0.000000	2,397,182	67.00
68.00	06800	SPEECH PATHOLOGY	0	968,582	0.000000	0.000000	695,076	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,674,426	0.000000	0.000000	7,635,132	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,104,238	0.000000	0.000000	458,071	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	72,804,541	0.000000	0.000000	9,161,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,601,116	0.000000	0.000000	7,642,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	114,935,755	0.000000	0.000000	31,698,697	73.00
74.00	07400	RENAL DIALYSIS	0	3,073,954	0.000000	0.000000	2,203,725	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.02	09001	PROCEDURE CLINIC	0	12,287,964	0.000000	0.000000	116,960	90.02
90.03	09004	IMMEDIATE CARE CENTER	0	0	0.000000	0.000000	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0	720,236	0.000000	0.000000	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	10,535,260	0.000000	0.000000	3,724	90.05
91.00	09100	EMERGENCY	0	100,583,665	0.000000	0.000000	12,433,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,230,954	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	1,162,348,306			217,519,845	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 12/1/2014 2:15 pm
--	----------------------	---	--

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)	Hospital	PPS
Title XVIII		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	11,231,264	0		50.00
50.01	05001 ENDOSCOPY	0	12,421,037	0		50.01
51.00	05100 RECOVERY ROOM	0	1,499,256	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	2,806,324	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,112,126	0		54.00
54.01	03630 ULTRASOUND	0	3,631,838	0		54.01
54.02	05401 RADIOLOGY-SPECIAL PROCEDURES	0	2,032,517	0		54.02
54.03	03440 MAMMOGRAPHY	0	587,687	0		54.03
55.00	05500 RADIOLOGY-THERAPEUTIC	0	6,677,290	0		55.00
56.00	05600 RADIOISOTOPE	0	5,792,497	0		56.00
57.00	05700 CT SCAN	0	14,854,520	0		57.00
58.00	05800 MRI	0	7,958,987	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	4,902,791	0		59.00
60.00	06000 LABORATORY	0	7,837,372	0		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	461,914	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	150,348	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	791,317	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
66.01	06601 REHAB OUTPATIENT	0	366	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	4,546,313	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	686,160	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,532,854	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,382,195	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,228,785	0		73.00
74.00	07400 RENAL DIALYSIS	0	70,521	0		74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.02	09001 PROCEDURE CLINIC	0	5,448,710	0		90.02
90.03	09004 IMMEDIATE CARE CENTER	0	0	0		90.03
90.04	09002 EPILEPSY MONITORING UNIT	0	56,334	0		90.04
90.05	09003 OFFSITE IMAGING CENTER	0	2,809,022	0		90.05
91.00	09100 EMERGENCY	0	10,895,181	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3,057,142	0		92.00
200.00	Total (lines 50-199)	0	137,462,668	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 12/1/2014 2:15 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.145484	11,231,264	0	0	1,633,969	50.00
50.01 05001 ENDOSCOPY	0.092395	12,421,037	0	0	1,147,642	50.01
51.00 05100 RECOVERY ROOM	0.139278	1,499,256	0	0	208,813	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.394157	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.021250	2,806,324	0	0	59,634	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.192865	6,112,126	0	0	1,178,815	54.00
54.01 03630 ULTRASOUND	0.083661	3,631,838	0	0	303,843	54.01
54.02 05401 RADIOLOGY-SPECIAL PROCEDURES	0.175632	2,032,517	0	0	356,975	54.02
54.03 03440 MAMMOGRAPHY	0.187141	587,687	0	0	109,980	54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0.176799	6,677,290	0	0	1,180,538	55.00
56.00 05600 RADIO SOTOPE	0.058761	5,792,497	0	0	340,373	56.00
57.00 05700 CT SCAN	0.031633	14,854,520	0	0	469,893	57.00
58.00 05800 MRI	0.043026	7,958,987	0	0	342,443	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.138778	4,902,791	0	0	680,400	59.00
60.00 06000 LABORATORY	0.079486	7,837,372	20,700	0	622,961	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.320793	461,914	0	0	148,179	63.00
64.00 06400 INTRAVENOUS THERAPY	0.157877	150,348	0	0	23,736	64.00
65.00 06500 RESPIRATORY THERAPY	0.151758	791,317	0	0	120,089	65.00
66.00 06600 PHYSICAL THERAPY	0.240110	0	0	0	0	66.00
66.01 06601 REHAB OUTPATIENT	0.284014	366	0	0	104	66.01
67.00 06700 OCCUPATIONAL THERAPY	0.251205	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.230214	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.062364	4,546,313	0	0	283,526	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.122248	686,160	0	0	83,882	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.264232	6,532,854	0	0	1,726,189	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.899890	2,382,195	0	0	2,143,713	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.208636	11,228,785	127	302,653	2,342,729	73.00
74.00 07400 RENAL DIALYSIS	0.327966	70,521	0	0	23,128	74.00
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.02 09001 PROCEDURE CLINIC	0.470499	5,448,710	0	0	2,563,613	90.02
90.03 09004 IMMEDIATE CARE CENTER	0.000000	0	0	0	0	90.03
90.04 09002 EPILEPSY MONITORING UNIT	0.458621	56,334	0	0	25,836	90.04
90.05 09003 OFFSITE IMAGING CENTER	0.083989	2,809,022	0	0	235,927	90.05
91.00 09100 EMERGENCY	0.194460	10,895,181	94,454	0	2,118,677	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.871254	3,057,142	0	0	2,663,547	92.00
200.00 Subtotal (see instructions)		137,462,668	115,281	302,653	23,139,154	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		137,462,668	115,281	302,653	23,139,154	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 12/1/2014 2:15 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
50.01 05001 ENDOSCOPY	0	0		50.01
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03630 ULTRASOUND	0	0		54.01
54.02 05401 RADIOLOGY-SPECIAL PROCEDURES	0	0		54.02
54.03 03440 MAMMOGRAPHY	0	0		54.03
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	1,645	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06601 REHAB OUTPATIENT	0	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	26	63,144		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.02 09001 PROCEDURE CLINIC	0	0		90.02
90.03 09004 IMMEDIATE CARE CENTER	0	0		90.03
90.04 09002 EPILEPSY MONITORING UNIT	0	0		90.04
90.05 09003 OFFSITE IMAGING CENTER	0	0		90.05
91.00 09100 EMERGENCY	18,368	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	20,039	63,144		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	20,039	63,144		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 12/1/2014 2:15 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		66,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		66,621	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)		58,234	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)		25,474	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)		84,646,543	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)		84,646,543	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)		84,646,543	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,270.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		32,366,500	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)		32,366,500	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
		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	11,263,138	4,923	2,287.86	2,468	5,646,438	43.00
43.01	NEONATAL NICU	13,386,019	3,027	4,422.21	0	0	43.01
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)					36,813,409	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					74,826,347	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)					4,520,175	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,096,948	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					6,617,123	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					68,209,224	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)					8,387	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,270.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					10,656,271	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 12/1/2014 2:15 pm	
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	10,611,312	84,646,543	0.125360	10,656,271	1,335,870	90.00
91.00	Nursing School cost	0	84,646,543	0.000000	10,656,271	0	91.00
92.00	Allied health cost	0	84,646,543	0.000000	10,656,271	0	92.00
93.00	All other Medical Education	0	84,646,543	0.000000	10,656,271	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 12/1/2014 2:15 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		66,621	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		66,621	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)		58,234	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)		9,300	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)		10,248	15.00
16.00	Nursery days (title V or XIX only)		3,891	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)		84,646,025	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)		84,646,025	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)		84,646,025	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,270.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,816,208	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)		11,816,208	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 12/1/2014 2:15 pm	
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)	1,468,514	10,248	143.30	3,891	557,580	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	11,263,138	4,923	2,287.86	263	601,707	43.00
43.01	NEONATAL NICU	13,386,019	3,027	4,422.21	1,338	5,916,917	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					18,892,412	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					8,387	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,270.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					10,656,187	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140290		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 12/1/2014 2:15 pm	
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	10,611,312	84,646,025	0.125361	10,656,187	1,335,870	90.00
91.00	Nursing School cost	0	84,646,025	0.000000	10,656,187	0	91.00
92.00	Allied health cost	0	84,646,025	0.000000	10,656,187	0	92.00
93.00	All other Medical Education	0	84,646,025	0.000000	10,656,187	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 12/1/2014 2:15 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		60,174,312	30.00
31.00	03100	INTENSIVE CARE UNIT		10,763,080	31.00
31.01	02060	NEONATAL NICU		0	31.01
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.145486	18,548,636	50.00
50.01	05001	ENDOSCOPY	0.092395	5,755,319	50.01
51.00	05100	RECOVERY ROOM	0.139278	3,621,439	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.394157	71,811	52.00
53.00	05300	ANESTHESIOLOGY	0.021259	4,190,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.192865	6,271,297	54.00
54.01	03630	ULTRASOUND	0.083661	4,037,208	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0.175632	2,247,704	54.02
54.03	03440	MAMMOGRAPHY	0.187141	1,981	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.176799	382,192	55.00
56.00	05600	RADIOISOTOPE	0.058761	4,311,330	56.00
57.00	05700	CT SCAN	0.031633	12,257,807	57.00
58.00	05800	MRI	0.043026	5,106,804	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.138778	6,905,246	59.00
60.00	06000	LABORATORY	0.079486	37,048,191	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320793	1,991,610	63.00
64.00	06400	INTRAVENOUS THERAPY	0.157877	1,894,510	64.00
65.00	06500	RESPIRATORY THERAPY	0.151758	22,395,469	65.00
66.00	06600	PHYSICAL THERAPY	0.240110	6,035,170	66.00
66.01	06601	REHAB OUTPATIENT	0.284014	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.251205	2,397,182	67.00
68.00	06800	SPEECH PATHOLOGY	0.230214	695,076	68.00
69.00	06900	ELECTROCARDIOLOGY	0.062364	7,635,132	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.122248	458,071	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.264232	9,161,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.899890	7,642,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.208636	31,698,697	73.00
74.00	07400	RENAL DIALYSIS	0.327966	2,203,725	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.02	09001	PROCEDURE CLINIC	0.470499	116,960	90.02
90.03	09004	IMMEDIATE CARE CENTER	0.000000	0	90.03
90.04	09002	EPILEPSY MONITORING UNIT	0.458621	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0.083989	3,724	90.05
91.00	09100	EMERGENCY	0.194460	12,433,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.871254	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		217,519,845	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)		217,519,845	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Prepared: 12/1/2014 2:15 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	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)		11,287,970		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		33,863,909		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)		1,738,294		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)		256.02		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	Adjustment 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)		2.39		30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.58		31.00
32.00	Sum of lines 30 and 31		25.97		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Prepared: 12/1/2014 2:15 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		10.64	1.01	
34.00	Disproportionate share adjustment (see instructions)		2,101,820		
			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)				9,046,380,143
35.01	Factor 3 (see instructions)				0.000525065
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				4,749,938
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				3,552,692
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,552,692		
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		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		
47.00	Subtotal (see instructions)		52,544,685		
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		52,544,685		
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		3,970,882		
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		
53.00	Nursing and Allied Health Managed Care payment		0		
54.00	Special add-on payments for new technologies		0		
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		0		
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0		
59.00	Total (sum of amounts on lines 49 through 58)		56,515,567		
60.00	Primary payer payments		461,004		
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		56,054,563		
62.00	Deductibles billed to program beneficiaries		4,340,032		
63.00	Coinurance billed to program beneficiaries		187,744		
64.00	Allowable bad debts (see instructions)		752,524		
65.00	Adjusted reimbursable bad debts (see instructions)		489,141		

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Prepared: 12/1/2014 2:15 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		650,690		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		52,015,928		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
70.01	OTHER ADJUSTMENTS		3,086		70.01
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)		138,725		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-154,658		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)		52,003,081		71.00
71.01	Sequestration adjustment (see instructions)		1,040,062		71.01
72.00	Interim payments		50,441,454		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		521,565		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		116,401		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: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 12/1/2014 2:15 pm
		Title XVII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		83,183	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		23,139,154	2.00
3.00	PPS payments		19,621,663	3.00
4.00	Outlier payment (see instructions)		19,421	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)		83,183	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		417,934	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)		417,934	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		417,934	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		334,751	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)		83,183	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)		19,641,084	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		18,922	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,453,361	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)		15,251,984	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)		15,251,984	30.00
31.00	Primary payer payments		34,176	31.00
32.00	Subtotal (line 30 minus line 31)		15,217,808	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)		888,420	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		577,473	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		786,666	36.00
37.00	Subtotal (see instructions)		15,795,281	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-3,005	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)		15,798,286	40.00
40.01	Sequestration adjustment (see instructions)		315,966	40.01
41.00	Interim payments		15,247,389	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		234,931	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: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
12/1/2014 2:15 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		50,051,479		14,873,689		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		389,975		373,700		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)		50,441,454		15,247,389		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		521,565		234,931		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		50,963,019		15,482,320		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: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 12/1/2014 2:15 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			15,991 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			27,942 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			2,761 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			66,184 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			1,356,945,714 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			50,669,454 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,795,704 8.00
9.00	Sequestration adjustment amount (see instructions)			35,914 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,759,790 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			1,759,790 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 12/1/2014 2:15 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		18,892,412		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		18,892,412	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		18,892,412	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		18,892,412	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		18,892,412	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet G

Date/Time Prepared:
12/1/2014 2:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	22,046,929	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	40,601,844	0	0	0	4.00
5.00	Other receivable	445,298	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,246,781	0	0	0	7.00
8.00	Prepaid expenses	321,241	0	0	0	8.00
9.00	Other current assets	410,904	0	0	0	9.00
10.00	Due from other funds	890,917	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	68,963,914	0	0	0	11.00
FIXED ASSETS						
12.00	Land	12,220,000	0	0	0	12.00
13.00	Land improvements	14,359	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	244,963,030	0	0	0	15.00
16.00	Accumulated depreciation	-31,509,609	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	35,712,839	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	3,843,225	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	265,243,844	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,374,524	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	12,823	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,387,347	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	335,595,105	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,118,535	0	0	0	37.00
38.00	Salaries, wages, and fees payable	14,065,299	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	469,404	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	21,052,610	0	0	0	43.00
44.00	Other current liabilities	33,875,597	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	70,581,445	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,770,914	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,770,914	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	78,352,359	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	257,242,746	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	257,242,746	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	335,595,105	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-1

Date/Time Prepared:
12/1/2014 2:15 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		257,221,214		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		21,532			2.00
3.00	Total (sum of line 1 and line 2)		257,242,746		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		257,242,746		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		257,242,746		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			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: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
12/1/2014 2:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	133,700,350		133,700,350	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				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	133,700,350		133,700,350	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	20,389,644		20,389,644	11.00
11.01	NEONATAL NICU	29,514,979		29,514,979	11.01
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)	49,904,623		49,904,623	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	183,604,973		183,604,973	17.00
18.00	Ancillary services	502,600,991	678,035,028	1,180,636,019	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PATIENT REVENUES	0	745,008	745,008	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	686,205,964	678,780,036	1,364,986,000	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		329,981,390		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	BAD DEBTS	16,205,139			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)		16,205,139		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		313,776,251		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140290

Period:
From 07/01/2013
To 06/30/2014

Worksheet G-3

Date/Time Prepared:
12/1/2014 2:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,364,986,000	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,059,747,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	305,239,000	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	313,776,251	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,537,251	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	952,274	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	16,014	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	38,798	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	12,035	21.00
22.00	Rental of hospital space	683,257	22.00
23.00	Governmental appropriations	0	23.00
24.00	MEANINGFUL USE	2,453,805	24.00
24.01	REVENUE FROM GIFT SHOP	291,018	24.01
24.02	FOUNDATION RESTRICTED FUNDS	611,560	24.02
24.03	INCOME FROM EASE, MENT	180,872	24.03
24.04	SURGICENTER JV	790,935	24.04
24.05	READMIT ALPHA TEAM	125,447	24.05
24.06	STARBUCKS	368,880	24.06
24.07	INTERCOMPANY LAB	11,987	24.07
24.08	MISCELLANEOUS INCOME	2,021,901	24.08
25.00	Total other income (sum of lines 6-24)	8,558,783	25.00
26.00	Total (line 5 plus line 25)	21,532	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	21,532	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140290	Period: From 07/01/2013 To 06/30/2014	Worksheet L Parts I-III Date/Time Prepared: 12/1/2014 2:15 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,603,815	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		172,461	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)		181.33	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)		2.39	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		23.58	8.00
9.00	Sum of lines 7 and 8		25.97	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.40	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		194,606	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		3,970,882	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