

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: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 4/29/2015 3:46 pm
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<b>PART I - COST REPORT STATUS</b>			
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: 4/29/2015	Time: 3:46 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 ADVOCATE EUREKA HOSPITAL ( 141309 ) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	109,799	192,261	5,651	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
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	-120,616	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00 Total	0	-10,817	192,261	5,651	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 141309		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 4/29/2015 3:15 pm				
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 101 SOUTH MAJOR STREET			PO Box:				1.00					
2.00	City: EUREKA			State: IL		Zip Code: 61530		County: WOODFORD			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		ADVOCATE EUREKA HOSPITAL		141309	99914	1	01/01/2001	N	0	0	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		EUREKA SWING BED		14Z309	99914		01/01/2001	N	0	N	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	
17.10	Hospital-Based (CORF) I											17.10	
18.00	Renal Dialysis											18.00	
19.00	Other											19.00	
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2014	12/31/2014		20.00			
21.00	Type of Control (see instructions)						1		21.00				
Inpatient PPS Information													
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N		23.00			
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
				1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 4/29/2015 3:15 pm		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
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 Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141309

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
<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 Nonprovider Settings</u>						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
<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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141309		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 4/29/2015 3:15 pm	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0		76.00
				1.00			
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N			81.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00

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				V	XIX		
				1.00	2.00		
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y			90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N			91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N			92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N			93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N			94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y					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)	N					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N					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.	Y					108.00
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
					1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N			110.00
					1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N			0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	9,280	0	52,572			118.01
					1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
<b>Transplant Center Information</b>							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141309		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 4/29/2015 3:15 pm	
		1.00	2.00				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00			
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00			
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00			
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H036	140.00			
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ADVOCATE HEALTH CARE	Contractor's Name: NGS		Contractor's Number: 00130		141.00	
142.00	Street: 3075 HIGHLAND PARKWAY	PO Box:				142.00	
143.00	City: DOWNERS GROVE	State: IL		Zip Code: 60515		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00				
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00				
				1.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N	146.00				
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00				
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00				
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00				
		Part A	Part B	Title V	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	
161.10	CORF		N	N	N	161.10	
						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 (see instructions)						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					Y	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)					6,307	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)					0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 4/29/2015 3:15 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		01/01/2014	12/31/2014	170.00
			1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 4/29/2015 3:15 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)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y		Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/08/2015	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: 141309

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
4/29/2015 3:15 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
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.	JULIE		BARGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5758		JULIE.BARGER@ADVOCATEHEALTH.COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/14/2014	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	
<b>Cost Report Preparer Contact Information</b>			
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.	SR REIMB SPECIALIST	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: 141309

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 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	23	8,395	15,984.00	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)		23	8,395	15,984.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		23	8,395	15,984.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		23				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: 141309

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 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)	451	19	647			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	745	0	1,014			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,196	19	1,661			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,196	19	1,661	0.00	80.78	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	80.78	27.00
28.00 Observation Bed Days		7	96			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: 141309

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 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	217	8	314	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	217	8	314	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	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
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					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



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141309

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

Worksheet A  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	0	392,122	392,122	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	456,840	456,840	2.00	
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	187,263	825,228	1,012,491	1,128,607	4.00	
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	204,581	255,600	460,181	457,377	5.01	
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	466,226	3,569,061	4,035,287	-658,960	3,376,327	5.02
7.00	00700	OPERATION OF PLANT	106,429	483,932	590,361	-36,798	553,563	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	27,873	27,873	8.00
9.00	00900	HOUSEKEEPING	129,252	49,057	178,309	-3,138	175,171	9.00
10.00	01000	DIETARY	139,988	63,190	203,178	-3,123	200,055	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,179	4,772	64,951	0	64,951	14.00
15.00	01500	PHARMACY	140,870	399,755	540,625	-357,848	182,777	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	225,152	69,138	294,290	-10	294,280	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	752,717	185,717	938,434	-67,947	870,487	30.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	414,981	202,199	617,180	-138,251	478,929	50.00
53.00	05300	ANESTHESIOLOGY	306,524	46,533	353,057	-28,341	324,716	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	639,345	570,526	1,209,871	-222,371	987,500	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	396,322	542,310	938,632	-28,089	910,543	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	62,827	130,974	193,801	-5,790	188,011	65.00
66.00	06600	PHYSICAL THERAPY	277,320	31,318	308,638	-5,210	303,428	66.00
67.00	06700	OCCUPATIONAL THERAPY	83,373	6,693	90,066	45	90,111	67.00
68.00	06800	SPEECH PATHOLOGY	15,054	58,414	73,468	-38,273	35,195	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	263,492	263,492	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,692	7,692	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	365,961	365,961	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	528,638	913,866	1,442,504	-33,188	1,409,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,137,041	8,408,283	13,545,324	0	13,545,324	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0	194.02
194.03	07953	EDUCATION	2,193	3,723	5,916	0	5,916	194.03
194.04	07954	SCHOOL THERAPY	360,556	31,184	391,740	0	391,740	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118-199)	5,499,790	8,443,190	13,942,980	0	13,942,980	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141309

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

Worksheet A  
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	22,170	414,292	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	156,787	613,627	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200,556	1,329,163	4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	-22,941	434,436	5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,426,592	1,949,735	5.02
7.00	00700	OPERATION OF PLANT	3,171	556,734	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,873	55,746	8.00
9.00	00900	HOUSEKEEPING	0	175,171	9.00
10.00	01000	DIETARY	-2,712	197,343	10.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	64,951	14.00
15.00	01500	PHARMACY	8,680	191,457	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,018	291,262	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	870,487	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	478,929	50.00
53.00	05300	ANESTHESIOLOGY	0	324,716	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,411	976,089	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-11,430	899,113	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	188,011	65.00
66.00	06600	PHYSICAL THERAPY	-238	303,190	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	90,111	67.00
68.00	06800	SPEECH PATHOLOGY	-4,386	30,809	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	263,492	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,692	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	365,961	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	0	1,409,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,063,491	12,481,833	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	194.02
194.03	07953	EDUCATION	0	5,916	194.03
194.04	07954	SCHOOL THERAPY	0	391,740	194.04
194.05	07955	VACANT SPACE	0	0	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-1,063,491	12,879,489	200.00

RECLASSIFICATIONS

Provider CCN: 141309

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

Worksheet A-6  
Date/Time Prepared:  
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - RECLASS DRUGS CHARGED TO PATIENTS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	365,961	1.00
	TOTALS		0	365,961	
<b>B - RECLASS BLOOD EXPENSE</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	3,117	1.00
2.00	OPERATING ROOM	50.00	0	11,638	2.00
3.00	EMERGENCY	91.00	0	1,870	3.00
	TOTALS		0	16,625	
<b>C - RECLASS MOVABLE EQUIPMENT DEPREC</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	378,835	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
	TOTALS		0	378,835	
<b>D - RECLASS BLDG DEPRECIATION</b>					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	392,122	1.00
	TOTALS		0	392,122	
<b>E - RECLASS MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	413,261	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0	45	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		0	413,306	
<b>F - RECLASS LAB REAGENTS AND BLOOD</b>					
1.00	LABORATORY	60.00	0	142,077	1.00
	TOTALS		0	142,077	
<b>G - RECLASS IMPLANT COSTS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,692	1.00
	TOTALS		0	7,692	
<b>H - BROMENN HOME OFFICE</b>					
1.00	LAUNDRY & LINEN SERVICE	8.00	13,257	14,616	1.00
2.00	OPERATION OF PLANT	7.00	13,518	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	13,826	0	3.00
4.00	PHARMACY	15.00	8,680	0	4.00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	116,116	5.00
6.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	78,005	6.00
	TOTALS		49,281	208,737	
500.00	Grand Total: Increases		49,281	1,925,355	500.00

RECLASSIFICATIONS

Provider CCN: 141309

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

Worksheet A-6  
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - RECLASS DRUGS CHARGED TO PATIENTS</b>							
1.00	PHARMACY	15.00	0	365,961	0		1.00
	TOTALS		0	365,961			
<b>B - RECLASS BLOOD EXPENSE</b>							
1.00	LABORATORY	60.00	0	16,625	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	16,625			
<b>C - RECLASS MOVABLE EQUIPMENT DEPREC</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	8,211	9		1.00
2.00	OPERATION OF PLANT	7.00	0	27,696	0		2.00
3.00	HOUSEKEEPING	9.00	0	1,226	0		3.00
4.00	DIETARY	10.00	0	1,730	0		4.00
5.00	PHARMACY	15.00	0	554	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	31,409	0		6.00
7.00	OPERATING ROOM	50.00	0	62,625	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	22,112	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	194,731	0		9.00
10.00	LABORATORY	60.00	0	17,317	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	2,156	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	1,842	0		12.00
13.00	EMERGENCY	91.00	0	7,226	0		13.00
	TOTALS		0	378,835			
<b>D - RECLASS BLDG DEPRECIATION</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	392,122	9		1.00
	TOTALS		0	392,122			
<b>E - RECLASS MEDICAL SUPPLIES</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	2,804	0		1.00
2.00	OPERATION OF PLANT	7.00	0	22,620	0		2.00
3.00	HOUSEKEEPING	9.00	0	1,912	0		3.00
4.00	DIETARY	10.00	0	1,393	0		4.00
6.00	PHARMACY	15.00	0	13	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	10	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	39,655	0		8.00
9.00	OPERATING ROOM	50.00	0	87,264	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	6,229	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41,466	0		11.00
12.00	LABORATORY	60.00	0	136,224	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	3,634	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	3,368	0		14.00
16.00	SPEECH PATHOLOGY	68.00	0	38,273	0		16.00
17.00	EMERGENCY	91.00	0	27,832	0		17.00
18.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	609	0		18.00
	TOTALS		0	413,306			
<b>F - RECLASS LAB REAGENTS AND BLOOD</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	142,077	0		1.00
	TOTALS		0	142,077			
<b>G - RECLASS IMPLANT COSTS</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,692	0		1.00
	TOTALS		0	7,692			
<b>H - BROMENN HOME OFFICE</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	49,281	208,737	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	9		6.00
	TOTALS		49,281	208,737			
500.00	Grand Total: Decreases		49,281	1,925,355			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141309

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	281,203	0	0	0	0	1.00
2.00	Land Improvements	304,598	804,124	0	804,124	0	2.00
3.00	Buildings and Fixtures	9,034,442	1,506,559	0	1,506,559	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,903,137	20,619	0	20,619	33,590	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,523,380	2,331,302	0	2,331,302	33,590	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,523,380	2,331,302	0	2,331,302	33,590	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	281,203	0				1.00
2.00	Land Improvements	1,108,722	213,379				2.00
3.00	Buildings and Fixtures	10,541,001	4,449,765				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5,890,166	3,485,266				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	17,821,092	8,148,410				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	17,821,092	8,148,410				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141309

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
4/29/2015 3:15 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141309

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
4/29/2015 3:15 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	NEW CAP REL COSTS-BLDG & FIXT	9,620,243	0	9,620,243	0.619726	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,903,137	0	5,903,137	0.380274	0	2.00
3.00	Total (sum of lines 1-2)	15,523,380	0	15,523,380	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	414,292	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	613,627	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,027,919	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	414,292	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	613,627	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,027,919	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst. A-7	Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00		0	7.00
8.00 Television and radio service (chapter 21)			0		0.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-6,010	0				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	-549,147					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-2,712	0	DIETARY	10.00		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	-3,018	0	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-7,015	0	CAP REL COSTS-MVBLE EQUIP	2.00		9	32.00

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	
33.00 OTHER OPERATING REVENUE	B	-83,660	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 33.00
33.02 OTHER OPERATING REVENUE	B	-10,347	OPERATION OF PLANT	7.00	0 33.02
33.03 OTHER OPERATING REVENUE	B	-25,227	RADIOLOGY-DIAGNOSTIC	54.00	0 33.03
33.04 OTHER OPERATING REVENUE	B	-131	PHYSICAL THERAPY	66.00	0 33.04
33.05 OTHER OPERATING REVENUE	B	-4,386	SPEECH PATHOLOGY	68.00	0 33.05
33.06 OTHER OPERATING REVENUE	B	-5,430	LABORATORY	60.00	0 33.06
33.07		0		0.00	0 33.07
33.08 ADVERTISING AND CUST RELATIONS	A	-22,941	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 33.08
33.09 LOBBYING	A	-5,200	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 33.09
33.10 MISC PROMOTIONAL	A	-107	PHYSICAL THERAPY	66.00	0 33.10
33.11		0		0.00	0 33.11
33.14 PERSONAL PROP LOSS & PATIENT FUNDS	A	-283	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 33.14
33.15 IDPA TAX ASSESSMENT	A	-196,685	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 33.15
33.16 PROPERTY AND OTHER TAXES	A	-23,269	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 33.16
33.17 MD REFERRAL	A	-2,717	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.17
33.18 CHARITABLE CONTRIB & COMMUNITY SUPPO	A	-452	OTHER ADMINISTRATIVE AND GENERAL	5.02	0 33.18
33.20 EMPLOYEE HEALTH SELF INS COST	A	-114,754	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.20
33.21		0		0.00	0 33.21
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,063,491			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: 141309

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

Worksheet A-8-1

Date/Time Prepared: 4/29/2015 3:15 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	BUILDINGS & FIXTURES	22,170	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	MOVABLE EQUIPMENT	163,802	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EH&W	318,027	0
4.00	5.02	OTHER ADMINISTRATIVE AND GEN	DATA PROCESSING	1,271,541	2,388,584
4.03	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	27,873	0
4.04	7.00	OPERATION OF PLANT	PLANT OPERATIONS	13,518	0
4.05	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY	13,826	0
4.06	0.00			0	0
4.07	15.00	PHARMACY	PHARMACY	8,680	0
4.09	0.00			0	0
4.10	0.00			0	0
4.11	0.00			0	0
4.12	0.00			0	0
4.13	0.00			0	0
4.14	0.00			0	0
4.15	0.00			0	0
5.00	0	0	0	1,839,437	2,388,584

\* 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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

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

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

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

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

Provider CCN: 141309

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

Worksheet A-8-1

Date/Time Prepared:  
4/29/2015 3:15 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	22,170	9		1.00
2.00	163,802	9		2.00
3.00	318,027	0		3.00
4.00	-1,117,043	0		4.00
4.03	27,873	0		4.03
4.04	13,518	0		4.04
4.05	13,826	0		4.05
4.06	0	0		4.06
4.07	8,680	0		4.07
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
5.00	-549,147			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>		

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

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

6.00	HEALTHCARE		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: 141309

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

Worksheet A-8-2

Date/Time Prepared:  
4/29/2015 3:15 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	91.00	EMERGENCY	765,965	0	765,965	0	0	1.00
2.00	54.00	DR. A	10	10	0	0	0	2.00
3.00	5.02	DR. B	38,850	0	38,850	0	0	3.00
4.00	60.00	DR. C	6,000	6,000	0	0	0	4.00
5.00	0.00		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			810,825	6,010	804,815	0	0	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	54.00	DR. A	0	0	0	0	0	2.00
3.00	5.02	DR. B	0	0	0	0	0	3.00
4.00	60.00	DR. C	0	0	0	0	0	4.00
5.00	0.00		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			0	0	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	91.00	EMERGENCY	0	0	0	0		1.00
2.00	54.00	DR. A	0	0	0	10		2.00
3.00	5.02	DR. B	0	0	0	0		3.00
4.00	60.00	DR. C	0	0	0	6,000		4.00
5.00	0.00		0	0	0	0		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	0	0	6,010		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141309

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

Worksheet B Part I Date/Time Prepared: 4/29/2015 3:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	414,292	414,292			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	613,627		613,627		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,329,163	0	0	1,329,163	4.00
5.01 00561	OTHER ADMINISTRATIVE AND GENERAL	434,436	9,941	0	51,185	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	1,949,735	24,741	11,376	104,317	2,090,169 5.02
7.00 00700	OPERATION OF PLANT	556,734	37,563	31,920	30,010	656,227 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	55,746	0	0	3,317	59,063 8.00
9.00 00900	HOUSEKEEPING	175,171	4,093	2,047	32,338	213,649 9.00
10.00 01000	DIETARY	197,343	28,376	2,888	35,024	263,631 10.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	64,951	8,853	0	15,056	88,860 14.00
15.00 01500	PHARMACY	191,457	0	925	37,417	229,799 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	291,262	36,042	0	56,332	383,636 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	870,487	43,634	52,430	188,327	1,154,878 30.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	478,929	62,179	104,538	103,826	749,472 50.00
53.00 05300	ANESTHESIOLOGY	324,716	0	36,911	76,690	438,317 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	976,089	61,945	325,059	163,419	1,526,512 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	899,113	14,850	28,907	99,157	1,042,027 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	188,011	0	3,599	15,719	207,329 65.00
66.00 06600	PHYSICAL THERAPY	303,190	51,572	3,075	69,384	427,221 66.00
67.00 06700	OCCUPATIONAL THERAPY	90,111	0	0	20,859	110,970 67.00
68.00 06800	SPEECH PATHOLOGY	30,809	0	0	3,766	34,575 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	263,492	0	0	0	263,492 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	7,692	0	0	0	7,692 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	365,961	0	0	0	365,961 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00 09100	EMERGENCY	1,409,316	30,503	9,952	132,262	1,582,033 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,481,833	414,292	613,627	1,238,405	12,391,075 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0 194.00
194.01 07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0 194.01
194.02 07952	RENTAL PROPERTIES	0	0	0	0	0 194.02
194.03 07953	EDUCATION	5,916	0	0	549	6,465 194.03
194.04 07954	SCHOOL THERAPY	391,740	0	0	90,209	481,949 194.04
194.05 07955	VACANT SPACE	0	0	0	0	0 194.05
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	12,879,489	414,292	613,627	1,329,163	12,879,489 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141309

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

Worksheet B Part I Date/Time Prepared: 4/29/2015 3:15 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.01	Subtotal 5A.01	OTHER ADMINISTRATIVE AND GENERAL 5.02	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561	495,562					5.01
5.02	00560	83,634	2,173,803	2,173,803			5.02
7.00	00700	26,260	682,487	138,580	821,067		7.00
8.00	00800	2,364	61,427	12,473	0	73,900	8.00
9.00	00900	8,550	222,199	45,118	9,824	0	9.00
10.00	01000	10,550	274,181	55,673	68,116	0	10.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	3,556	92,416	18,765	21,251	0	14.00
15.00	01500	9,196	238,995	48,528	0	0	15.00
16.00	01600	15,352	398,988	81,015	86,517	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	46,215	1,201,093	243,883	104,741	73,900	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	29,992	779,464	158,271	149,259	0	50.00
53.00	05300	17,540	455,857	92,562	0	0	53.00
54.00	05400	61,086	1,587,598	322,363	148,697	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	41,699	1,083,726	220,052	35,646	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	8,297	215,626	43,783	0	0	65.00
66.00	06600	17,096	444,317	90,219	123,795	0	66.00
67.00	06700	4,441	115,411	23,434	0	0	67.00
68.00	06800	1,384	35,959	7,302	0	0	68.00
71.00	07100	10,544	274,036	55,643	0	0	71.00
72.00	07200	308	8,000	1,624	0	0	72.00
73.00	07300	14,645	380,606	77,282	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	63,308	1,645,341	334,092	73,221	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		476,017	12,371,530	2,070,662	821,067	73,900	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	259	6,724	1,365	0	0	194.03
194.04	07954	19,286	501,235	101,776	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		495,562	12,879,489	2,173,803	821,067	73,900	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141309

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	277,141					9.00
10.00	01000	7,399	405,369				10.00
13.00	01300	0	0	0			13.00
14.00	01400	10,173	0	0	142,605		14.00
15.00	01500	0	0	0	648	288,171	15.00
16.00	01600	7,707	0	0	323	673	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	67,820	405,369	0	2,219	3,692	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	40,076	0	0	4,044	3,161	50.00
53.00	05300	0	0	0	0	26	53.00
54.00	05400	41,001	0	0	0	529	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	15,722	0	0	52,590	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	4,316	0	0	10	0	65.00
66.00	06600	15,106	0	0	979	0	66.00
67.00	06700	0	0	0	33	0	67.00
68.00	06800	0	0	0	22	0	68.00
71.00	07100	0	0	0	75,195	0	71.00
72.00	07200	0	0	0	2,195	0	72.00
73.00	07300	0	0	0	0	275,373	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	67,821	0	0	3,611	4,717	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
118.00		277,141	405,369	0	141,869	288,171	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	683	0	194.03
194.04	07954	0	0	0	53	0	194.04
194.05	07955	0	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		277,141	405,369	0	142,605	288,171	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141309

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	19.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
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
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	575,223				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	575,223	0	0	2,677,940	0 30.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	1,134,275	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	548,445	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,100,188	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	0	0	1,407,736	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	263,735	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	674,416	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	138,878	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	43,283	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	404,874	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,819	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	733,261	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	09100	EMERGENCY	0	0	0	2,128,803	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	575,223	0	0	12,267,653	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0 194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0 194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0 194.02
194.03	07953	EDUCATION	0	0	0	8,772	0 194.03
194.04	07954	SCHOOL THERAPY	0	0	0	603,064	0 194.04
194.05	07955	VACANT SPACE	0	0	0	0	0 194.05
200.00		Cross Foot Adjustments	0	0	0	0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	575,223	0	0	12,879,489	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared: 4/29/2015 3:15 pm
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00561 OTHER ADMINISTRATIVE AND GENERAL		5.01
5.02	00560 OTHER ADMINISTRATIVE AND GENERAL		5.02
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
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	2,677,940	30.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	1,134,275	50.00
53.00	05300 ANESTHESIOLOGY	548,445	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,100,188	54.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	1,407,736	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	263,735	65.00
66.00	06600 PHYSICAL THERAPY	674,416	66.00
67.00	06700 OCCUPATIONAL THERAPY	138,878	67.00
68.00	06800 SPEECH PATHOLOGY	43,283	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	404,874	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11,819	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	733,261	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	09100 EMERGENCY	2,128,803	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910 CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,267,653	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100 RESEARCH	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300 NONPAID WORKERS	0	193.00
194.00	07950 TOWN & COUNTRY RHC BLD	0	194.00
194.01	07951 WOODFORD PUBLIC HEALTH	0	194.01
194.02	07952 RENTAL PROPERTIES	0	194.02
194.03	07953 EDUCATION	8,772	194.03
194.04	07954 SCHOOL THERAPY	603,064	194.04
194.05	07955 VACANT SPACE	0	194.05
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	12,879,489	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141309

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

Worksheet B  
Part II  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01 00561	OTHER ADMINISTRATIVE AND GENERAL	723	9,941	0	10,664	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	6,329	24,741	11,376	42,446	5.02
7.00 00700	OPERATION OF PLANT	0	37,563	31,920	69,483	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	4,093	2,047	6,140	9.00
10.00 01000	DIETARY	0	28,376	2,888	31,264	10.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	8,853	0	8,853	14.00
15.00 01500	PHARMACY	7,309	0	925	8,234	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,953	36,042	0	39,995	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	33,609	43,634	52,430	129,673	30.00
41.00 04100	SUBPROVIDER - IIRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	77	62,179	104,538	166,794	50.00
53.00 05300	ANESTHESIOLOGY	0	0	36,911	36,911	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	61,945	325,059	387,004	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	12,045	14,850	28,907	55,802	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	3,599	3,599	65.00
66.00 06600	PHYSICAL THERAPY	58	51,572	3,075	54,705	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	2,434	30,503	9,952	42,889	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	66,537	414,292	613,627	1,094,456	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	TOWN & COUNTRY RHC BLD	0	0	0	0	194.00
194.01 07951	WOODFORD PUBLIC HEALTH	0	0	0	0	194.01
194.02 07952	RENTAL PROPERTIES	0	0	0	0	194.02
194.03 07953	EDUCATION	0	0	0	0	194.03
194.04 07954	SCHOOL THERAPY	0	0	0	0	194.04
194.05 07955	VACANT SPACE	0	0	0	0	194.05
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118-201)	66,537	414,292	613,627	1,094,456	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141309

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

Worksheet B  
Part II  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.01	OTHER ADMINISTRATIVE AND GENERAL 5.02	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561	10,664					5.01
5.02	00560	1,800	44,246				5.02
7.00	00700	565	2,821	72,869			7.00
8.00	00800	51	254	0	305		8.00
9.00	00900	184	918	872	0	8,114	9.00
10.00	01000	227	1,133	6,045	0	217	10.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	77	382	1,886	0	298	14.00
15.00	01500	198	988	0	0	0	15.00
16.00	01600	330	1,649	7,678	0	226	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	994	4,964	9,296	305	1,986	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	645	3,222	13,246	0	1,173	50.00
53.00	05300	377	1,884	0	0	0	53.00
54.00	05400	1,314	6,562	13,197	0	1,200	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	897	4,479	3,164	0	460	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	179	891	0	0	126	65.00
66.00	06600	368	1,836	10,987	0	442	66.00
67.00	06700	96	477	0	0	0	67.00
68.00	06800	30	149	0	0	0	68.00
71.00	07100	227	1,133	0	0	0	71.00
72.00	07200	7	33	0	0	0	72.00
73.00	07300	315	1,573	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	1,362	6,798	6,498	0	1,986	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
118.00		10,243	42,146	72,869	305	8,114	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	6	28	0	0	0	194.03
194.04	07954	415	2,072	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		10,664	44,246	72,869	305	8,114	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141309

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

Worksheet B  
Part II  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	38,886					10.00
13.00	01300	0	0				13.00
14.00	01400	0	0	11,496			14.00
15.00	01500	0	0	52	9,472		15.00
16.00	01600	0	0	26	22	49,926	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	38,886	0	179	121	49,926	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	326	104	0	50.00
53.00	05300	0	0	0	1	0	53.00
54.00	05400	0	0	0	17	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	4,239	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	1	0	0	65.00
66.00	06600	0	0	79	0	0	66.00
67.00	06700	0	0	3	0	0	67.00
68.00	06800	0	0	2	0	0	68.00
71.00	07100	0	0	6,062	0	0	71.00
72.00	07200	0	0	177	0	0	72.00
73.00	07300	0	0	0	9,052	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	0	291	155	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		38,886	0	11,437	9,472	49,926	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	55	0	0	194.03
194.04	07954	0	0	4	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		38,886	0	11,496	9,472	49,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141309

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

Worksheet B  
Part II  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	19.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL					5.02
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	236,330	0	236,330	30.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	185,510	0	185,510	50.00
53.00	05300	ANESTHESIOLOGY	0	39,173	0	39,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	409,294	0	409,294	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	69,041	0	69,041	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	4,796	0	4,796	65.00
66.00	06600	PHYSICAL THERAPY	0	68,417	0	68,417	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	576	0	576	67.00
68.00	06800	SPEECH PATHOLOGY	0	181	0	181	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,422	0	7,422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	217	0	217	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,940	0	10,940	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	59,979	0	59,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	1,091,876	0	1,091,876
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	194.02
194.03	07953	EDUCATION	0	89	0	89	194.03
194.04	07954	SCHOOL THERAPY	0	2,491	0	2,491	194.04
194.05	07955	VACANT SPACE	0	0	0	0	194.05
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	1,094,456	0	1,094,456

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141309

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

Worksheet B-1

Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	33,507				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		367,601			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,312,527		4.00
5.01 00561	OTHER ADMINISTRATIVE AND GENERAL	804	0	204,581	-495,562	5.01
5.02 00560	OTHER ADMINISTRATIVE AND GENERAL	2,001	6,815	416,945	0	5.02
7.00 00700	OPERATION OF PLANT	3,038	19,122	119,947	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	13,257	0	8.00
9.00 00900	HOUSEKEEPING	331	1,226	129,252	0	9.00
10.00 01000	DIETARY	2,295	1,730	139,988	0	10.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	716	0	60,179	0	14.00
15.00 01500	PHARMACY	0	554	149,550	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,915	0	225,152	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	3,529	31,409	752,717	0	30.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	5,029	62,625	414,981	0	50.00
53.00 05300	ANESTHESIOLOGY	0	22,112	306,524	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,010	194,731	653,171	0	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,201	17,317	396,322	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	2,156	62,827	0	65.00
66.00 06600	PHYSICAL THERAPY	4,171	1,842	277,320	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	83,373	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	15,054	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	2,467	5,962	528,638	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,582,033	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	33,507	367,601	4,949,778	-495,562	11,895,513
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	TOWN & COUNTRY RHC BLD	0	0	0	0	194.00
194.01 07951	WOODFORD PUBLIC HEALTH	0	0	0	0	194.01
194.02 07952	RENTAL PROPERTIES	0	0	0	0	194.02
194.03 07953	EDUCATION	0	0	2,193	0	194.03
194.04 07954	SCHOOL THERAPY	0	0	360,556	0	194.04
194.05 07955	VACANT SPACE	0	0	0	0	194.05
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)	414,292	613,627	1,329,163		495,562
203.00	Unit cost multiplier (Wkst. B, Part I)	12.364342	1.669275	0.250194		0.040017
204.00	Cost to be allocated (per Wkst. B, Part II)			0		10,664
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.000861

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141309

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

Worksheet B-1

Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A.02	5.02	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL	-2,173,803	10,705,686			5.02
7.00	00700	OPERATION OF PLANT	0	682,487	27,664		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,427	0	54,040	8.00
9.00	00900	HOUSEKEEPING	0	222,199	331	0	4,495 9.00
10.00	01000	DIETARY	0	274,181	2,295	0	120 10.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	92,416	716	0	165 14.00
15.00	01500	PHARMACY	0	238,995	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	398,988	2,915	0	125 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	1,201,093	3,529	54,040	1,100 30.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	779,464	5,029	0	650 50.00
53.00	05300	ANESTHESIOLOGY	0	455,857	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,587,598	5,010	0	665 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	1,083,726	1,201	0	255 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	215,626	0	0	70 65.00
66.00	06600	PHYSICAL THERAPY	0	444,317	4,171	0	245 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	115,411	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	35,959	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	274,036	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,000	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	380,606	0	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	09100	EMERGENCY	0	1,645,341	2,467	0	1,100 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0 111.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,173,803	10,197,727	27,664	54,040	4,495 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	0	0	0	0 194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	0	0	0	0 194.01
194.02	07952	RENTAL PROPERTIES	0	0	0	0	0 194.02
194.03	07953	EDUCATION	0	6,724	0	0	0 194.03
194.04	07954	SCHOOL THERAPY	0	501,235	0	0	0 194.04
194.05	07955	VACANT SPACE	0	0	0	0	0 194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		2,173,803	821,067	73,900	277,141 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.203051	29.679981	1.367506	61.655395 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		44,246	72,869	305	8,114 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.004133	2.634073	0.005644	1.805117 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141309

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

Worksheet B-1

Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		DIETARY (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITION)	PHARMACY (COSTED REQUISITION)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	200					10.00
13.00	01300	0	0				13.00
14.00	01400	0	0	499,714			14.00
15.00	01500	0	0	2,272	382,969		15.00
16.00	01600	0	0	1,131	895	200	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	200	0	7,776	4,906	200	30.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	14,172	4,201	0	50.00
53.00	05300	0	0	0	34	0	53.00
54.00	05400	0	0	0	703	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	184,286	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	0	34	0	0	65.00
66.00	06600	0	0	3,432	0	0	66.00
67.00	06700	0	0	116	0	0	67.00
68.00	06800	0	0	77	0	0	68.00
71.00	07100	0	0	263,492	0	0	71.00
72.00	07200	0	0	7,692	0	0	72.00
73.00	07300	0	0	0	365,961	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	0	12,655	6,269	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		200	0	497,135	382,969	200	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	2,395	0	0	194.03
194.04	07954	0	0	184	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
200.00							200.00
201.00							201.00
202.00		405,369	0	142,605	288,171	575,223	202.00
203.00		2,026.845000	0.000000	0.285373	0.752466	2,876.115000	203.00
204.00		38,886	0	11,496	9,472	49,926	204.00
205.00		194.430000	0.000000	0.023005	0.024733	249.630000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141309

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

Worksheet B-1  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL		5.01
5.02	00560	OTHER ADMINISTRATIVE AND GENERAL		5.02
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
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910	CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	TOWN & COUNTRY RHC BLD	0	194.00
194.01	07951	WOODFORD PUBLIC HEALTH	0	194.01
194.02	07952	RENTAL PROPERTIES	0	194.02
194.03	07953	EDUCATION	0	194.03
194.04	07954	SCHOOL THERAPY	0	194.04
194.05	07955	VACANT SPACE	0	194.05
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141309

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 pm

		Title XVIII		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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	2,677,940		2,677,940	0	0 30.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0 41.00
42.00	04200 SUBPROVIDER	0		0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	1,134,275		1,134,275	0	0 50.00
53.00	05300 ANESTHESIOLOGY	548,445		548,445	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,100,188		2,100,188	0	0 54.00
57.00	05700 CT SCAN	0		0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	1,407,736		1,407,736	0	0 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	263,735	0	263,735	0	0 65.00
66.00	06600 PHYSICAL THERAPY	674,416	0	674,416	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	138,878	0	138,878	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	43,283	0	43,283	0	0 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	404,874		404,874	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11,819		11,819	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	733,261		733,261	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
91.00	09100 EMERGENCY	2,128,803		2,128,803	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	146,319		146,319	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF	0		0		0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900 PANCREAS ACQUISITION	0		0		0 109.00
110.00	11000 INTESTINAL ACQUISITION	0		0		0 110.00
111.00	11100 ISLET ACQUISITION	0		0		0 111.00
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	12,413,972	0	12,413,972	0	0 200.00
201.00	Less Observation Beds	146,319		146,319		0 201.00
202.00	Total (see instructions)	12,267,653	0	12,267,653	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141309

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 pm

		Title XVIII			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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,084,515		1,084,515		30.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	30,465	1,546,503	1,576,968	0.719276	50.00
53.00	05300	ANESTHESIOLOGY	24,972	162,670	187,642	2.922826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	617,208	7,530,849	8,148,057	0.257753	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	741,093	5,020,144	5,761,237	0.244346	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	25,705	655,986	681,691	0.386884	65.00
66.00	06600	PHYSICAL THERAPY	225,525	648,521	874,046	0.771602	66.00
67.00	06700	OCCUPATIONAL THERAPY	76,840	157,135	233,975	0.593559	67.00
68.00	06800	SPEECH PATHOLOGY	8,407	19,653	28,060	1.542516	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	166,793	169,858	336,651	1.202652	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,268	16,268	0.726518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,589,349	1,675,985	3,265,334	0.224559	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	215,757	2,995,290	3,211,047	0.662962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,284	89,834	94,118	1.554634	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,810,913	20,688,696	25,499,609		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,810,913	20,688,696	25,499,609		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 4/29/2015 3:15 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
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: 141309

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		2,677,940	0	2,677,940	30.00
41.00	04100 SUBPROVIDER - IRF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		1,134,275	0	1,134,275	50.00
53.00	05300 ANESTHESIOLOGY		548,445	0	548,445	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,100,188	0	2,100,188	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		1,407,736	0	1,407,736	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	263,735	0	263,735	65.00
66.00	06600 PHYSICAL THERAPY	0	674,416	0	674,416	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	138,878	0	138,878	67.00
68.00	06800 SPEECH PATHOLOGY	0	43,283	0	43,283	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		404,874	0	404,874	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		11,819	0	11,819	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		733,261	0	733,261	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	09100 EMERGENCY		2,128,803	0	2,128,803	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		146,319	0	146,319	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF		0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
113.00	11300 INTEREST EXPENSE		0	0	0	113.00
200.00	Subtotal (see instructions)		12,413,972	0	12,413,972	200.00
201.00	Less Observation Beds		146,319	0	146,319	201.00
202.00	Total (see instructions)		12,267,653	0	12,267,653	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141309

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,084,515		1,084,515		30.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	30,465	1,546,503	1,576,968	0.719276	50.00
53.00	05300	ANESTHESIOLOGY	24,972	162,670	187,642	2.922826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	617,208	7,530,849	8,148,057	0.257753	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	741,093	5,020,144	5,761,237	0.244346	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	25,705	655,986	681,691	0.386884	65.00
66.00	06600	PHYSICAL THERAPY	225,525	648,521	874,046	0.771602	66.00
67.00	06700	OCCUPATIONAL THERAPY	76,840	157,135	233,975	0.593559	67.00
68.00	06800	SPEECH PATHOLOGY	8,407	19,653	28,060	1.542516	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	166,793	169,858	336,651	1.202652	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,268	16,268	0.726518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,589,349	1,675,985	3,265,334	0.224559	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	215,757	2,995,290	3,211,047	0.662962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,284	89,834	94,118	1.554634	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,810,913	20,688,696	25,499,609		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,810,913	20,688,696	25,499,609		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 4/29/2015 3:15 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
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 ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 4/29/2015 3:15 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	185,510	1,576,968	0.117637	7,665	902	50.00
53.00	05300 ANESTHESIOLOGY	39,173	187,642	0.208765	2,336	488	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	409,294	8,148,057	0.050232	281,949	14,163	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	69,041	5,761,237	0.011984	283,169	3,393	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	4,796	681,691	0.007035	11,641	82	65.00
66.00	06600 PHYSICAL THERAPY	68,417	874,046	0.078276	95,844	7,502	66.00
67.00	06700 OCCUPATIONAL THERAPY	576	233,975	0.002462	31,133	77	67.00
68.00	06800 SPEECH PATHOLOGY	181	28,060	0.006450	3,250	21	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,422	336,651	0.022047	81,077	1,788	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	217	16,268	0.013339	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,940	3,265,334	0.003350	688,440	2,306	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	59,979	3,211,047	0.018679	91,097	1,702	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	30,535	94,118	0.324433	1,967	638	92.00
200.00	Total (lines 50-199)	886,081	24,415,094		1,579,568	33,062	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141309

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

Worksheet D  
Part IV  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141309

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

Worksheet D  
Part IV  
Date/Time Prepared:  
4/29/2015 3:15 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		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	1,576,968	0.000000	0.000000	7,665	50.00
53.00	05300 ANESTHESIOLOGY	0	187,642	0.000000	0.000000	2,336	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,148,057	0.000000	0.000000	281,949	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	5,761,237	0.000000	0.000000	283,169	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	681,691	0.000000	0.000000	11,641	65.00
66.00	06600 PHYSICAL THERAPY	0	874,046	0.000000	0.000000	95,844	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	233,975	0.000000	0.000000	31,133	67.00
68.00	06800 SPEECH PATHOLOGY	0	28,060	0.000000	0.000000	3,250	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	336,651	0.000000	0.000000	81,077	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	16,268	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,265,334	0.000000	0.000000	688,440	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	3,211,047	0.000000	0.000000	91,097	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	94,118	0.000000	0.000000	1,967	92.00
200.00	Total (lines 50-199)	0	24,415,094			1,579,568	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 4/29/2015 3:15 pm
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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)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital Cost					
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141309

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

Worksheet D  
Part V  
Date/Time Prepared:  
4/29/2015 3:15 pm

		Title XVIII		Hospital		Cost		
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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.719276	0	623,096	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2.922826	0	59,805	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.257753	0	2,985,617	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.244346	0	3,009,876	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.386884	0	212,819	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.771602	0	241,873	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.593559	0	38,467	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.542516	0	12,370	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202652	0	103,086	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.726518	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224559	0	601,751	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.662962	0	767,927	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.554634	0	60,291	0	0	92.00
200.00		Subtotal (see instructions)		0	8,716,978	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	8,716,978	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 4/29/2015 3:15 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	448,178	0	50.00
53.00	05300 ANESTHESIOLOGY	174,800	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	769,552	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	735,451	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	82,336	0	65.00
66.00	06600 PHYSICAL THERAPY	186,630	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	22,832	0	67.00
68.00	06800 SPEECH PATHOLOGY	19,081	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	123,977	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	135,129	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100 EMERGENCY	509,106	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	93,730	0	92.00
200.00	Subtotal (see instructions)	3,300,802	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,300,802	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141309

Period:

Worksheet D

Component CCN: 14Z309

From 01/01/2014  
To 12/31/2014

Part V  
Date/Time Prepared:  
4/29/2015 3:15 pm

Title XVIII

Swing Beds - SNF

Cost

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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.719276	0	0	0	0
53.00 05300 ANESTHESIOLOGY	2.922826	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.257753	0	0	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.244346	0	0	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.386884	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.771602	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.593559	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	1.542516	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202652	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.726518	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.224559	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
91.00 09100 EMERGENCY	0.662962	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.554634	0	0	0	0
200.00 Subtotal (see instructions)		0	0	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141309 Component CCN: 14Z309	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 4/29/2015 3:15 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 4/29/2015 3:15 pm
	Title XIX	Hospital	Cost

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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.719276	0	146,968	0	0
53.00 05300 ANESTHESIOLOGY	2.922826	0	15,240	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.257753	0	1,040,935	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.244346	0	544,467	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.386884	0	66,147	0	0
66.00 06600 PHYSICAL THERAPY	0.771602	0	66,354	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.593559	0	4,837	0	0
68.00 06800 SPEECH PATHOLOGY	1.542516	0	688	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202652	0	10,167	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.726518	0	1,320	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.224559	0	217,484	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
91.00 09100 EMERGENCY	0.662962	0	847,039	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.554634	0	6,951	0	0
200.00 Subtotal (see instructions)		0	2,968,597	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	2,968,597	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141309

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

Worksheet D  
Part V  
Date/Time Prepared:  
4/29/2015 3:15 pm

		Title XIX		Hospital	Cost
Cost Center Description	Costs		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	105,711	0	50.00
53.00	05300	ANESTHESIOLOGY	44,544	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	268,304	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	133,038	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	25,591	0	65.00
66.00	06600	PHYSICAL THERAPY	51,199	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,871	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,061	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,227	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	959	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,838	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	561,555	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,806	0	92.00
200.00		Subtotal (see instructions)	1,266,704	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	1,266,704	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII		Hospital
				Date/Time Prepared: 4/29/2015 3:15 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,757	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		743	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)		647	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,014	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)		451	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)		745	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		120.63	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,677,940	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)		1,545,488	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,132,452	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		1,132,452	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,524.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		687,392	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)		687,392	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141309		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 4/29/2015 3:15 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)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					571,708		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,259,100		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)					1,135,492		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)					1,135,492		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)						96	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,524.16	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						146,319	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141309		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 4/29/2015 3:15 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	236,330	1,132,452	0.208689	146,319	30,535	90.00
91.00	Nursing School cost	0	1,132,452	0.000000	146,319	0	91.00
92.00	Allied health cost	0	1,132,452	0.000000	146,319	0	92.00
93.00	All other Medical Education	0	1,132,452	0.000000	146,319	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 4/29/2015 3:15 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		475,601		30.00
41.00	04100 SUBPROVIDER - I RF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.719276	7,665	5,513	50.00
53.00	05300 ANESTHESIOLOGY	2.922826	2,336	6,828	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.257753	281,949	72,673	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.244346	283,169	69,191	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.386884	11,641	4,504	65.00
66.00	06600 PHYSICAL THERAPY	0.771602	95,844	73,953	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.593559	31,133	18,479	67.00
68.00	06800 SPEECH PATHOLOGY	1.542516	3,250	5,013	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202652	81,077	97,507	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.726518	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.224559	688,440	154,595	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	0.662962	91,097	60,394	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.554634	1,967	3,058	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,579,568	571,708	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)		1,579,568		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3	
		Component CCN: 14Z309		Date/Time Prepared: 4/29/2015 3:15 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.719276	3,777	50.00
53.00	05300	ANESTHESIOLOGY	2.922826	1,151	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.257753	138,944	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.244346	139,545	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.386884	5,737	65.00
66.00	06600	PHYSICAL THERAPY	0.771602	47,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.593559	15,342	67.00
68.00	06800	SPEECH PATHOLOGY	1.542516	1,602	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.202652	39,955	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.726518	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224559	339,263	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.662962	44,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.554634	969	92.00
200.00		Total (sum of lines 50-94 and 96-98)		778,410	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)		778,410	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 4/29/2015 3:15 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			3,300,802 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,300,802 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,333,810 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			17,384 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,155,489 26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,160,937 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,160,937 30.00
31.00	Primary payer payments			47 31.00
32.00	Subtotal (line 30 minus line 31)			2,160,890 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			83,653 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			63,576 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			83,653 36.00
37.00	Subtotal (see instructions)			2,224,466 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,224,466 40.00
40.01	Sequestration adjustment (see instructions)			44,489 40.01
41.00	Interim payments			1,987,716 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			192,261 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 141309

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 pm

		Title XVIII		Hospital		Cost	
		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		948,661		1,896,336	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/18/2014	46,564	08/18/2014	56,831	3.01	
3.02		12/18/2014	18,107	12/18/2014	34,549	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)		64,671		91,380	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,013,332		1,987,716	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		109,799		192,261	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,123,131		2,179,977	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141309  
Component CCN: 14Z309

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/29/2015 3:15 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,254,439		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/18/2014	182,298		0	3.01
3.02		12/18/2014	67,138		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)		249,436		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,503,875		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		120,616		0	6.02
7.00	Total Medicare program liability (see instructions)		1,383,259		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 141309

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
4/29/2015 3:15 pm

		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			314 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			451 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			0 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			647 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			25,499,609 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			616,668 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			6,307 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			5,766 8.00
9.00	Sequestration adjustment amount (see instructions)			115 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			5,651 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
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)			5,651 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141309  
Component CCN: 14Z309

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

Worksheet E-2  
Date/Time Prepared:  
4/29/2015 3:15 pm

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,146,847	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	284,554	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	745	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,431,401	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	1,431,401	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	1,431,401	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	19,912	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,411,489	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50	
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	1,411,489	0	19.00	
19.01	Sequestration adjustment (see instructions)	28,230	0	19.01	
20.00	Interim payments	1,503,875	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-120,616	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141309	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 4/29/2015 3:15 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services			1,259,100 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,259,100 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,271,691 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	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 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,271,691 19.00
20.00	Deductibles (exclude professional component)			133,696 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,137,995 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,137,995 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			10,601 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			8,057 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			7,232 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,146,052 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			1,146,052 30.00
30.01	Sequestration adjustment (see instructions)			22,921 30.01
31.00	Interim payments			1,013,332 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)			109,799 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

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

Provider CCN: 141309

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

Worksheet G

Date/Time Prepared:  
4/29/2015 3:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	148,055,000	0	0	0	1.00
2.00	Temporary investments	78,257,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	500,298,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	161,836,000	0	0	0	9.00
10.00	Due from other funds	26,699,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	915,145,000	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	112,769,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,353,442,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	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	1,234,419,000	0	0	0	23.00
24.00	Accumulated depreciation	-2,002,101,000	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,698,529,000	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	4,254,171,000	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	383,091,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,637,262,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,250,936,000	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	263,764,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	415,910,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	29,129,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	440,019,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,148,822,000	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	1,424,101,000	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	936,224,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,360,325,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,509,147,000	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	3,741,789,000	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)	3,741,789,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,250,936,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141309

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

Worksheet G-1

Date/Time Prepared:  
4/29/2015 3:15 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		4,172,698,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-100,654			2.00
3.00	Total (sum of line 1 and line 2)		4,172,597,346		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	ADJ TO AHC FUND BALANCE	1,076,409,999		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)		1,076,409,999		0	10.00
11.00	Subtotal (line 3 plus line 10)		5,249,007,345		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)		5,249,007,345		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	ADJ TO AHC FUND BALANCE		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: 141309

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
4/29/2015 3:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	934,506		934,506	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	150,009		150,009	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)	1,084,515		1,084,515	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,084,515		1,084,515	17.00
18.00	Ancillary services	3,597,599	17,407,575	21,005,174	18.00
19.00	Outpatient services	0	4,476,585	4,476,585	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
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,682,114	21,884,160	26,566,274	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,942,980		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,942,980		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141309

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

Worksheet G-3

Date/Time Prepared:  
4/29/2015 3:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	26,566,274	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,262,464	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,303,810	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,942,980	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-639,170	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	310,815	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	191,309	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	40,726	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	-4,334	24.00
25.00	Total other income (sum of lines 6-24)	538,516	25.00
26.00	Total (line 5 plus line 25)	-100,654	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)	-100,654	29.00