

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: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/15/2015 7:45 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/15/2015 Time: 7:45 am	
	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.		
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 AURORA CHICAGO LAKESHORE (144005) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-114,797	31,658	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-114,797	31,658	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/15/2015 7:44 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 4840 N MARINE DRIVE			PO Box:						1.00		
2.00	City: CHICAGO			State: IL		Zip Code: 60640-7860		County: COOK		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		AURORA CHICAGO LAKESHORE		144005	16974	4	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2014	12/31/2014		20.00		
21.00	Type of Control (see instructions)						4		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.						0		23.00			
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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 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.			0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/15/2015 7:44 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete 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.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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

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		V	XIX				
		1.00	2.00				
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00		
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00		
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00		
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00		
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.		N		110.00		
		1.00	2.00	3.00			
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	Y	E	98		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.	Y			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:	343,897	0	0		118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02		
119.00	DO NOT USE THIS LINE				119.00		
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00		
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/15/2015 7:44 am	
		1.00		2.00			
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB0230		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: SIGNATURE HEALTHCARE	Contractor's Name: WPS		Contractor's Number: 08201		141.00	
142.00	Street: 29433 SOUTHFIELD ROAD	PO Box:				142.00	
143.00	City: SOUTHFIELD	State: MI		Zip Code: 48076		143.00	
		1.00		2.00		3.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y				145.00	
		1.00		2.00		3.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
		4.00		5.00		6.00	
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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
		1.00		2.00		3.00	
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	
		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		2.00		3.00	
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.	N				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/15/2015 7:44 am	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				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: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/15/2015 7:44 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	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	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/10/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 144005

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

Worksheet S-2
Part II
Date/Time Prepared:
5/15/2015 7:44 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			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
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PHILLIP		DORSEY	41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHEAST REIMBURSEMENT GROUP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	770-461-1435		PHILLIP.DORSEY@SRGLLC.ORG	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	03/10/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 144005

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

Worksheet S-3
Part I
Date/Time Prepared:
5/15/2015 7:44 am

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	76	27,740	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		76	27,740	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 CHILDRENS	35.00	60	21,900	0.00	0	12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		136	49,640	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	10	3,650			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		146				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: 144005

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

Worksheet S-3
Part I
Date/Time Prepared:
5/15/2015 7:44 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,000	3,061	27,647			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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,000	3,061	27,647			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 CHILDRENS	0	10,364	13,615			12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	6,000	13,425	41,262	0.00	287.80	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE			120	0.00	0.24	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	288.04	27.00
28.00 Observation Bed Days		0	0			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: 144005

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

Worksheet S-3
Part I
Date/Time Prepared:
5/15/2015 7:44 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	552	1,021	4,708	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 CHILDRENS							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	552	1,021	4,708		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE	0.00					34	21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144005

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

Worksheet A
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	3,407,159	3,407,159	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	281,866	281,866	2.00	
3.00	00300	OTHER CAP REL COSTS	369,912	369,912	-369,912	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113,532	1,703,356	0	1,703,356	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	5,355,891	7,094,900	12,450,791	-5,818,329	6,632,462	5.00
7.00	00700	OPERATION OF PLANT	203,646	701,617	905,263	-8,931	896,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	138,288	138,288	8.00
9.00	00900	HOUSEKEEPING	358,728	448,207	806,935	-138,288	668,647	9.00
10.00	01000	DIETARY	683,920	948,414	1,632,334	-210,337	1,421,997	10.00
11.00	01100	CAFETERIA	0	0	0	200,176	200,176	11.00
13.00	01300	NURSING ADMINISTRATION	1,220,718	191,716	1,412,434	0	1,412,434	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	819,620	236,471	1,056,091	0	1,056,091	16.00
17.00	01700	SOCIAL SERVICE	855,382	80,869	936,251	0	936,251	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,397,993	690,628	5,088,621	3,340,478	8,429,099	30.00
35.00	02400	CHILDRENS	3,193,892	349,153	3,543,045	1,753	3,544,798	35.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	9,553	9,553	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	254,893	254,893	-254,893	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	40,340	40,340	-40,340	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,062,441	1,062,441	-1,062,441	0	73.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	PARTIAL HOSPITAL	415,734	55,034	470,768	0	470,768	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,619,056	14,114,419	31,733,475	-524,198	31,209,277	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	PATIENT SCHOOL	94,100	9,010	103,110	-77,332	25,778	194.00
194.01	07951	NON REIMBURSABLE MEALS	0	0	0	0	0	194.01
194.02	07952	BUSINESS DEVELOPMENT	0	0	0	544,877	544,877	194.02
194.03	07953	PATIENT TRANSPORTATION	0	0	0	56,653	56,653	194.03
200.00		TOTAL (SUM OF LINES 118-199)	17,713,156	14,123,429	31,836,585	0	31,836,585	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144005

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

Worksheet A
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,666,104	1,741,055	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	281,866	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-47	1,703,309	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	275,433	6,907,895	5.00
7.00	00700	OPERATION OF PLANT	0	896,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	138,288	8.00
9.00	00900	HOUSEKEEPING	0	668,647	9.00
10.00	01000	DIETARY	-1,915	1,420,082	10.00
11.00	01100	CAFETERIA	-16,842	183,334	11.00
13.00	01300	NURSING ADMINISTRATION	-91	1,412,343	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,993	1,054,098	16.00
17.00	01700	SOCIAL SERVICE	-15	936,236	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,968,774	6,460,325	30.00
35.00	02400	CHILDRENS	-24,479	3,520,319	35.00
46.00	04600	OTHER LONG TERM CARE	0	9,553	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950	PARTIAL HOSPITAL	-4,947	465,821	93.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,409,774	27,799,503	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	PATIENT SCHOOL	0	25,778	194.00
194.01	07951	NON REIMBURSABLE MEALS	0	0	194.01
194.02	07952	BUSINESS DEVELOPMENT	0	544,877	194.02
194.03	07953	PATIENT TRANSPORTATION	0	56,653	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-3,409,774	28,426,811	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTS & LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,719,313	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	140,302	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	O		0	2,859,615	
B - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,367	1.00
	O		0	13,367	
C - MEDICAL PROFESSIONAL FEES					
1.00	ADULTS & PEDIATRICS	30.00	1,632,147	339,808	1.00
2.00	CHILDRENS	35.00	0	1,753	2.00
	O		1,632,147	341,561	
D - PATIENT TRANSPORTATION					
1.00	PATIENT TRANSPORTATION	194.03	49,891	6,762	1.00
	O		49,891	6,762	
E - CONTRACT LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	138,288	1.00
	O		0	138,288	
F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	372,215	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	73,916	2.00
	O		0	446,131	
G - PATIENT SCHOOL					
1.00	ADULTS & PEDIATRICS	30.00	70,575	6,757	1.00
	O		70,575	6,757	
H - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	83,870	116,306	1.00
	O		83,870	116,306	
I - BUSINESS DEVELOPMENT COSTS					
1.00	BUSINESS DEVELOPMENT	194.02	397,304	147,573	1.00
	O		397,304	147,573	
J - ANCILLARY SERVICES					
1.00	ADULTS & PEDIATRICS	30.00	0	1,357,674	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		0	1,357,674	
K - RTC COSTS					
1.00	OTHER LONG TERM CARE	46.00	8,586	967	1.00
	O		8,586	967	
500.00	Grand Total: Increases		2,242,373	5,435,001	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENTS & LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,840,246	10		1.00
2.00	OPERATION OF PLANT	7.00	0	8,931	10		2.00
3.00	DIETARY	10.00	0	10,161	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	277	0		4.00
	O		0	2,859,615			
B - INTEREST							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,367	11		1.00
	O		0	13,367			
C - MEDICAL PROFESSIONAL FEES							
1.00	ADMINISTRATIVE & GENERAL	5.00	1,632,147	341,561	0		1.00
2.00	O	0.00	0	0	0		2.00
	O		1,632,147	341,561			
D - PATIENT TRANSPORTATION							
1.00	ADULTS & PEDIATRICS	30.00	49,891	6,762	0		1.00
	O		49,891	6,762			
E - CONTRACT LAUNDRY							
1.00	HOUSEKEEPING	9.00	0	138,288	0		1.00
	O		0	138,288			
F - DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	446,131	9		1.00
2.00	O	0.00	0	0	9		2.00
	O		0	446,131			
G - PATIENT SCHOOL							
1.00	PATIENT SCHOOL	194.00	70,575	6,757	0		1.00
	O		70,575	6,757			
H - CAFETERIA COSTS							
1.00	DIETARY	10.00	83,870	116,306	0		1.00
	O		83,870	116,306			
I - BUSINESS DEVELOPMENT COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	397,304	147,573	0		1.00
	O		397,304	147,573			
J - ANCILLARY SERVICES							
1.00	LABORATORY	60.00	0	254,893	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	40,340	0		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,062,441	0		3.00
	O		0	1,357,674			
K - RTC COSTS							
1.00	ADULTS & PEDIATRICS	30.00	8,586	967	0		1.00
	O		8,586	967			
500.00	Grand Total: Decreases		2,242,373	5,435,001			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144005

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

Worksheet A-7
Part I
Date/Time Prepared:
5/15/2015 7:44 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	4,237,112	193,124	0	193,124	4.00
5.00	Fixed Equipment	223,663	36,719	0	36,719	5.00
6.00	Movable Equipment	865,932	183,857	0	183,857	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,326,707	413,700	0	413,700	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	5,326,707	413,700	0	413,700	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	4,430,236	0			4.00
5.00	Fixed Equipment	260,382	0			5.00
6.00	Movable Equipment	1,049,789	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	5,740,407	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	5,740,407	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144005

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

Worksheet A-7
Part II
Date/Time Prepared:
5/15/2015 7:44 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144005

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

Worksheet A-7
Part III
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	4,690,617	0	4,690,617	0.817123	34,549	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,049,789	0	1,049,789	0.182877	7,732	2.00
3.00	Total (sum of lines 1-2)	5,740,406	0	5,740,406	1.000000	42,281	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	267,715	0	302,264	372,215	1,053,209	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	59,916	0	67,648	73,916	140,302	2.00
3.00	Total (sum of lines 1-2)	327,631	0	369,912	446,131	1,193,511	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	13,367	34,549	267,715	0	1,741,055	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,732	59,916	0	281,866	2.00
3.00	Total (sum of lines 1-2)	13,367	42,281	327,631	0	2,022,921	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144005

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

Worksheet A-8

Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-179	0	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-115,060	0	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0	0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0	0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,977,385	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-1,141,254	0			0	12.00
13.00 Laundry and linen service		0	0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-16,842	0	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0	0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0	0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-1,993	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	0		0.00	0	19.00
20.00 Vending machines		0	0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	B	-10,071	0	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0	0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0	0		0.00	0	32.00
33.00 RENTAL INCOME/COMMISSION	B	-14,760	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 OTHER OPERATING REVENUE	B	-22,031	0	ADMINISTRATIVE & GENERAL	5.00	0	33.01

Provider CCN: 144005
 Period: From 01/01/2014 To 12/31/2014
 Worksheet A-8
 Date/Time Prepared: 5/15/2015 7:44 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
34.00	PHYSICIAN COSTS	A	-1,879	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CONTRIBUTIONS	A	-11,000	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING COSTS	A	-3,926	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PATIENT TRANSPORTATION	A	-47	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
37.01	PATIENT TRANSPORTATION	A	-47,200	ADMINISTRATIVE & GENERAL	5.00	0	37.01
37.02	PATIENT TRANSPORTATION	A	-91	NURSING ADMINISTRATION	13.00	0	37.02
37.03	PATIENT TRANSPORTATION	A	-15	SOCIAL SERVICE	17.00	0	37.03
37.04	PATIENT TRANSPORTATION	A	-15,868	ADULTS & PEDIATRICS	30.00	0	37.04
37.05	PATIENT TRANSPORTATION	A	-4,947	PARTIAL HOSPITAL	93.00	0	37.05
38.00	PENALTIES & FINES	A	-71	ADMINISTRATIVE & GENERAL	5.00	0	38.00
38.01	PENALTIES & FINES	A	-1,915	DIETARY	10.00	0	38.01
39.00	OTHER NON ALLOWABLE	A	-801	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	LEGAL FEES	A	-22,439	ADMINISTRATIVE & GENERAL	5.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,409,774				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: 144005

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

Worksheet A-8-1

Date/Time Prepared:
5/15/2015 7:44 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	1,483,474	873,600 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY COSTS	132,985	218,009 2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	OWNERSHIP COSTS	1,033,896	2,700,000 3.00
4.00	0.00			0	0 4.00
5.00	0			2,650,355	3,791,609 5.00

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

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

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

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

6.00	B	0.00	SIGNATURE HLTHC	100.00	6.00
7.00	D	0.00	KEBOK	100.00	7.00
8.00	D	0.00	IL MENTAL HLTH	100.00	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: 144005

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

Worksheet A-8-1

Date/Time Prepared:
5/15/2015 7:44 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	609,874	0		1.00
2.00	-85,024	0		2.00
3.00	-1,666,104	10		3.00
4.00	0	0		4.00
5.00	-1,141,254			5.00

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

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

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

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

6.00	HOSPITAL MGMT		6.00
7.00	COMPUTER SVCS		7.00
8.00	REIT		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: 144005

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

Worksheet A-8-2

Date/Time Prepared:
5/15/2015 7:44 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,040,921	1,918,142	122,779	154,100	1,188	1.00
2.00	35.00	AGGREGATE-CHILDREN	51,150	0	51,150	154,100	360	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			2,092,071	1,918,142	173,929		1,548	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	88,015	4,401	0	0	0	1.00
2.00	35.00	AGGREGATE-CHILDREN	26,671	1,334	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			114,686	5,735	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	88,015	34,764	1,952,906		1.00
2.00	35.00	AGGREGATE-CHILDREN	0	26,671	24,479	24,479		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		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	114,686	59,243	1,977,385		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144005

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,741,055	1,741,055			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	281,866		281,866		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,703,309	6,243	1,011	1,710,563	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,907,895	166,214	26,909	323,307	5.00
7.00 00700	OPERATION OF PLANT	896,332	102,872	16,654	19,793	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	138,288	0	0	0	8.00
9.00 00900	HOUSEKEEPING	668,647	8,686	1,406	34,866	9.00
10.00 01000	DIETARY	1,420,082	45,403	7,350	58,321	10.00
11.00 01100	CAFETERIA	183,334	36,322	5,880	8,152	11.00
13.00 01300	NURSING ADMINISTRATION	1,412,343	20,629	3,340	118,645	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,054,098	9,475	1,534	79,661	16.00
17.00 01700	SOCIAL SERVICE	936,236	0	0	83,137	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,460,325	1,014,731	164,280	587,267	30.00
35.00 02400	CHILDRENS	3,520,319	211,519	34,244	310,424	35.00
46.00 04600	OTHER LONG TERM CARE	9,553	0	0	834	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	PARTIAL HOSPITAL	465,821	107,709	17,437	40,406	93.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,799,503	1,729,803	280,045	1,664,813	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	8,414	1,362	0	192.00
194.00 07950	PATIENT SCHOOL	25,778	2,838	459	2,286	194.00
194.01 07951	NON REIMBURSABLE MEALS	0	0	0	0	194.01
194.02 07952	BUSINESS DEVELOPMENT	544,877	0	0	38,615	194.02
194.03 07953	PATIENT TRANSPORTATION	56,653	0	0	4,849	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	28,426,811	1,741,055	281,866	1,710,563	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144005

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

Worksheet B
Part I
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	7,424,325					5.00
7.00	00700	366,100	1,401,751				7.00
8.00	00800	48,884	0	187,172			8.00
9.00	00900	252,257	8,307	0	974,169		9.00
10.00	01000	541,259	43,421	0	30,356	2,146,192	10.00
11.00	01100	82,608	34,737	0	24,285	157,113	11.00
13.00	01300	549,673	19,728	0	13,792	0	13.00
16.00	01600	404,672	9,062	0	6,335	0	16.00
17.00	01700	360,345	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,908,088	970,442	125,048	678,445	1,305,616	30.00
35.00	02400	1,441,033	202,286	61,581	141,420	571,713	35.00
46.00	04600	3,672	0	543	0	5,672	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	223,188	103,007	0	72,013	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		7,181,779	1,390,990	187,172	966,646	2,040,114	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	3,456	8,047	0	5,626	0	192.00
194.00	07950	11,086	2,714	0	1,897	0	194.00
194.01	07951	0	0	0	0	106,078	194.01
194.02	07952	206,263	0	0	0	0	194.02
194.03	07953	21,741	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		7,424,325	1,401,751	187,172	974,169	2,146,192	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144005

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		11.00	13.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	532,431					11.00
13.00	01300	35,382	2,173,532				13.00
16.00	01600	33,989	156,649	1,755,475			16.00
17.00	01700	47,362	219,121	0	1,646,201		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	213,852	989,349	1,027,052	1,099,814	17,544,309	30.00
35.00	02400	160,139	740,824	505,399	541,613	8,442,514	35.00
46.00	04600	669	3,142	3,189	4,774	32,048	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	20,338	64,447	219,835	0	1,334,201	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		511,731	2,173,532	1,755,475	1,646,201	27,353,072	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	26,905	192.00
194.00	07950	1,198	0	0	0	48,256	194.00
194.01	07951	0	0	0	0	106,078	194.01
194.02	07952	15,044	0	0	0	804,799	194.02
194.03	07953	4,458	0	0	0	87,701	194.03
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		532,431	2,173,532	1,755,475	1,646,201	28,426,811	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144005

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

Worksheet B
Part I
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	17,544,309
35.00	02400	CHILDRENS	0	8,442,514
46.00	04600	OTHER LONG TERM CARE	0	32,048
ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0
60.00	06000	LABORATORY	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0
OUTPATIENT SERVICE COST CENTERS				
93.00	04950	PARTIAL HOSPITAL	0	1,334,201
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	27,353,072
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,905
194.00	07950	PATIENT SCHOOL	0	48,256
194.01	07951	NON REIMBURSABLE MEALS	0	106,078
194.02	07952	BUSINESS DEVELOPMENT	0	804,799
194.03	07953	PATIENT TRANSPORTATION	0	87,701
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	28,426,811

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144005

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

Worksheet B
Part II
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,243	1,011	7,254	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	54,463	166,214	26,909	247,586	5.00
7.00 00700	OPERATION OF PLANT	0	102,872	16,654	119,526	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	8,686	1,406	10,092	9.00
10.00 01000	DIETARY	0	45,403	7,350	52,753	10.00
11.00 01100	CAFETERIA	0	36,322	5,880	42,202	11.00
13.00 01300	NURSING ADMINISTRATION	0	20,629	3,340	23,969	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	9,475	1,534	11,009	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,014,731	164,280	1,179,011	30.00
35.00 02400	CHILDRENS	0	211,519	34,244	245,763	35.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	PARTIAL HOSPITAL	0	107,709	17,437	125,146	93.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	54,463	1,729,803	280,045	2,064,311	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	8,414	1,362	9,776	192.00
194.00 07950	PATIENT SCHOOL	0	2,838	459	3,297	194.00
194.01 07951	NON REIMBURSABLE MEALS	0	0	0	0	194.01
194.02 07952	BUSINESS DEVELOPMENT	0	0	0	0	194.02
194.03 07953	PATIENT TRANSPORTATION	0	0	0	0	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	54,463	1,741,055	281,866	2,077,384	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144005

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

Worksheet B
Part II
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	248,956					5.00
7.00	00700	12,277	131,887				7.00
8.00	00800	1,639	0	1,639			8.00
9.00	00900	8,459	782	0	19,481		9.00
10.00	01000	18,150	4,085	0	607	75,842	10.00
11.00	01100	2,770	3,268	0	486	5,552	11.00
13.00	01300	18,432	1,856	0	276	0	13.00
16.00	01600	13,570	853	0	127	0	16.00
17.00	01700	12,084	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	97,511	91,306	1,095	13,566	46,138	30.00
35.00	02400	48,323	19,033	539	2,828	20,203	35.00
46.00	04600	123	0	5	0	200	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	7,484	9,692	0	1,440	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1-117)		240,822	130,875	1,639	19,330	72,093	
NONREIMBURSABLE COST CENTERS							
192.00	19200	116	757	0	113	0	192.00
194.00	07950	372	255	0	38	0	194.00
194.01	07951	0	0	0	0	3,749	194.01
194.02	07952	6,917	0	0	0	0	194.02
194.03	07953	729	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		248,956	131,887	1,639	19,481	75,842	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144005

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

Worksheet B
Part II
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		11.00	13.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	54,313					11.00
13.00	01300	3,609	48,645				13.00
16.00	01600	3,467	3,506	32,870			16.00
17.00	01700	4,831	4,904	0	22,171		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	21,815	22,143	19,240	14,813	1,509,129	30.00
35.00	02400	16,336	16,580	9,457	7,294	387,672	35.00
46.00	04600	68	70	60	64	594	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	2,075	1,442	4,113	0	151,563	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		52,201	48,645	32,870	22,171	2,048,958	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	10,762	192.00
194.00	07950	122	0	0	0	4,094	194.00
194.01	07951	0	0	0	0	3,749	194.01
194.02	07952	1,535	0	0	0	8,616	194.02
194.03	07953	455	0	0	0	1,205	194.03
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		54,313	48,645	32,870	22,171	2,077,384	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144005

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

Worksheet B
Part II
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,509,129
35.00	02400	CHILDRENS	0	387,672
46.00	04600	OTHER LONG TERM CARE	0	594
ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0
60.00	06000	LABORATORY	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0
OUTPATIENT SERVICE COST CENTERS				
93.00	04950	PARTIAL HOSPITAL	0	151,563
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,048,958
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,762
194.00	07950	PATIENT SCHOOL	0	4,094
194.01	07951	NON REIMBURSABLE MEALS	0	3,749
194.02	07952	BUSINESS DEVELOPMENT	0	8,616
194.03	07953	PATIENT TRANSPORTATION	0	1,205
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	2,077,384

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144005

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

Worksheet B-1

Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	70,558				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		70,558			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	253	253	17,599,624		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,736	6,736	3,326,440	-7,424,325	5.00
7.00 00700	OPERATION OF PLANT	4,169	4,169	203,646	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	352	352	358,728	0	9.00
10.00 01000	DIETARY	1,840	1,840	600,050	0	10.00
11.00 01100	CAFETERIA	1,472	1,472	83,870	0	11.00
13.00 01300	NURSING ADMINISTRATION	836	836	1,220,718	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	384	384	819,620	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	855,382	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	41,123	41,123	6,042,238	0	30.00
35.00 02400	CHILDRENS	8,572	8,572	3,193,892	0	35.00
46.00 04600	OTHER LONG TERM CARE	0	0	8,586	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	PARTIAL HOSPITAL	4,365	4,365	415,734	0	93.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	70,102	70,102	17,128,904	-7,424,325	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	341	341	0	0	192.00
194.00 07950	PATIENT SCHOOL	115	115	23,525	0	194.00
194.01 07951	NON REIMBURSABLE MEALS	0	0	0	0	194.01
194.02 07952	BUSINESS DEVELOPMENT	0	0	397,304	0	194.02
194.03 07953	PATIENT TRANSPORTATION	0	0	49,891	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,741,055	281,866	1,710,563		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.675515	3.994813	0.097193		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			7,254		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000412		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144005

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

Worksheet B-1

Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERVED)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	59,400				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	41,382			8.00	
9.00	00900	HOUSEKEEPING	352	0	59,048		9.00	
10.00	01000	DIETARY	1,840	0	1,840	132,804	10.00	
11.00	01100	CAFETERIA	1,472	0	1,472	9,722	19,111	11.00
13.00	01300	NURSING ADMINISTRATION	836	0	836	0	1,270	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	384	0	384	0	1,220	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,700	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,123	27,647	41,123	80,790	7,676	30.00
35.00	02400	CHILDRENS	8,572	13,615	8,572	35,377	5,748	35.00
46.00	04600	OTHER LONG TERM CARE	0	120	0	351	24	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	PARTIAL HOSPITAL	4,365	0	4,365	0	730	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,944	41,382	58,592	126,240	18,368	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	341	0	341	0	0	192.00
194.00	07950	PATIENT SCHOOL	115	0	115	0	43	194.00
194.01	07951	NON REIMBURSABLE MEALS	0	0	0	6,564	0	194.01
194.02	07952	BUSINESS DEVELOPMENT	0	0	0	0	540	194.02
194.03	07953	PATIENT TRANSPORTATION	0	0	0	0	160	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,401,751	187,172	974,169	2,146,192	532,431	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.598502	4.523029	16.497917	16.160598	27.859924	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	131,887	1,639	19,481	75,842	54,313	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.220320	0.039607	0.329918	0.571082	2.841976	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144005

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

Worksheet B-1

Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300	352,096			13.00
16.00	01600	25,376	62,685,505		16.00
17.00	01700	35,496	0	41,382	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	160,267	36,674,125	27,647	30.00
35.00	02400	120,008	18,047,375	13,615	35.00
46.00	04600	509	113,885	120	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	0	0	0	54.00
60.00	06000	0	0	0	60.00
69.00	06900	0	0	0	69.00
73.00	07300	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950	10,440	7,850,120	0	93.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00					118.00
		352,096	62,685,505	41,382	
NONREIMBURSABLE COST CENTERS					
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
200.00					200.00
201.00					201.00
202.00		2,173,532	1,755,475	1,646,201	202.00
203.00		6.173123	0.028004	39.780605	203.00
204.00		48,645	32,870	22,171	204.00
205.00		0.138158	0.000524	0.535764	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144005

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

Worksheet C
Part I
Date/Time Prepared:
5/15/2015 7:44 am

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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	17,544,309		17,544,309	34,764	17,579,073 30.00	
35.00	02400 CHILDRENS	8,442,514		8,442,514	24,479	8,466,993 35.00	
46.00	04600 OTHER LONG TERM CARE	32,048		32,048	0	32,048 46.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0		0	0	0 54.00	
60.00	06000 LABORATORY	0		0	0	0 60.00	
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0 73.00	
OUTPATIENT SERVICE COST CENTERS							
93.00	04950 PARTIAL HOSPITAL	1,334,201		1,334,201	0	1,334,201 93.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						
200.00	Subtotal (see instructions)	27,353,072	0	27,353,072	59,243	27,412,315 200.00	
201.00	Less Observation Beds	0		0		0 201.00	
202.00	Total (see instructions)	27,353,072	0	27,353,072	59,243	27,412,315 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144005

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

Worksheet C
Part I
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,674,125		36,674,125		30.00
35.00	02400	CHILDRENS	18,047,375		18,047,375		35.00
46.00	04600	OTHER LONG TERM CARE	113,885		113,885		46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	PARTIAL HOSPITAL	0	7,850,120	7,850,120	0.169959	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	54,835,385	7,850,120	62,685,505		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	54,835,385	7,850,120	62,685,505		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144005

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

Worksheet C
Part I
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
35.00	02400 CHILDRENS				35.00
46.00	04600 OTHER LONG TERM CARE				46.00
	ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
	OUTPATIENT SERVICE COST CENTERS				
93.00	04950 PARTIAL HOSPITAL	0.169959			93.00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144005

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

Worksheet C
Part I
Date/Time Prepared:
5/15/2015 7:44 am

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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	17,544,309		17,544,309	34,764	17,579,073	30.00
35.00	02400 CHILDRENS	8,442,514		8,442,514	24,479	8,466,993	35.00
46.00	04600 OTHER LONG TERM CARE	32,048		32,048	0	32,048	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00	06000 LABORATORY	0		0	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950 PARTIAL HOSPITAL	1,334,201		1,334,201	0	1,334,201	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	27,353,072	0	27,353,072	59,243	27,412,315	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	27,353,072	0	27,353,072	59,243	27,412,315	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144005

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

Worksheet C
Part I
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	36,674,125		36,674,125		30.00
35.00	02400	CHILDRENS	18,047,375		18,047,375		35.00
46.00	04600	OTHER LONG TERM CARE	113,885		113,885		46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	PARTIAL HOSPITAL	0	7,850,120	7,850,120	0.169959	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	54,835,385	7,850,120	62,685,505		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	54,835,385	7,850,120	62,685,505		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/15/2015 7:44 am
		Title XIX	Hospital	Cost
Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
35.00	02400	CHILDRENS		35.00
46.00	04600	OTHER LONG TERM CARE		46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS				
93.00	04950	PARTIAL HOSPITAL	0.000000	93.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/15/2015 7:44 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,509,129	0	1,509,129	27,647	54.59	30.00
35.00	CHILDRENS	387,672		387,672	13,615	28.47	35.00
200.00	Total (lines 30-199)	1,896,801		1,896,801	41,262		200.00
INPATIENT ROUTINE SERVICE COST CENTERS							
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,000	327,540				
35.00	CHILDRENS	0	0				
200.00	Total (lines 30-199)	6,000	327,540				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/15/2015 7:44 am	
Title XVIII			Hospital		PPS			
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	0	0	0.000000	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	PARTIAL HOSPITAL	151,563	7,850,120	0.019307	0	0	93.00
200.00		Total (lines 50-199)	151,563	7,850,120		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/15/2015 7:44 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
35.00	02400	CHILDRENS	0	0	0	0	0	35.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,647	0.00	6,000	0		30.00
35.00	02400	CHILDRENS	13,615	0.00	0	0		35.00
200.00		Total (lines 30-199)	41,262		6,000	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/15/2015 7:44 am
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col . 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	PARTIAL HOSPITAL	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144005

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		Title XVIII			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0 54.00
60.00	06000	LABORATORY	0	0	0.000000	0.000000	0 60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0 69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0.000000	0.000000	0 73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	PARTIAL HOSPITAL	0	7,850,120	0.000000	0.000000	0 93.00
200.00		Total (lines 50-199)	0	7,850,120			0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144005

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
93.00	04950 PARTIAL HOSPITAL	0	825,057	0		93.00
200.00	Total (lines 50-199)	0	825,057	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/15/2015 7:44 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
60.00 06000	LABORATORY	0.000000	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	PARTIAL HOSPITAL	0.169959	825,057	0	140,226	93.00
200.00	Subtotal (see instructions)		825,057	0	140,226	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		825,057	0	140,226	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/15/2015 7:44 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950	PARTIAL HOSPITAL	0	0	93.00
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: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part V Date/Time Prepared: 5/15/2015 7:44 am		
			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		
ANCI LLARY SERVICE COST CENTERS									
54.00	05400	RADI OLOGY-DI AGNOSTI C	0.000000	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
69.00	06900	ELECTROCARDI OLOGY	0.000000	0	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
93.00	04950	PARTI AL HOSPI TAL	0.169959	0	0	1,337,257	0	0	93.00
200.00		Subtotal (see instructions)		0	0	1,337,257	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	0	1,337,257	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/15/2015 7:44 am
	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.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950	PARTIAL HOSPITAL	0	227,279	93.00
200.00		Subtotal (see instructions)	0	227,279	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	227,279	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/15/2015 7:44 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		27,647	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		27,647	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		27,647	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,000	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		17,579,073	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		17,579,073	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		17,579,073	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		635.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,815,040	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)		3,815,040	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/15/2015 7:44 am			
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)	
Title XVIII			1.00	2.00	3.00	4.00	5.00	
Hospital								
PPS								
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	CHILDRENS			8,466,993	13,615	621.89	0	47.00
Cost Center Description								
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						3,738,739	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)						327,540	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)						327,540	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						3,411,199	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/15/2015 7:44 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,509,129	17,579,073	0.085848	0	0	90.00
91.00	Nursing School cost	0	17,579,073	0.000000	0	0	91.00
92.00	Allied health cost	0	17,579,073	0.000000	0	0	92.00
93.00	All other Medical Education	0	17,579,073	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/15/2015 7:44 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		27,647	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		27,647	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		27,647	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,061	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		17,544,309	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		17,544,309	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		17,544,309	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		634.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,942,449	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,942,449	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1		
		Title XIX		Hospital		Date/Time Prepared: 5/15/2015 7:44 am		
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	CHILDRENS	8,442,514	13,615	620.09	10,364	6,426,613	47.00	
Cost Center Description								
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						8,201,681	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/15/2015 7:44 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,509,129	17,544,309	0.086018	0	0	90.00
91.00	Nursing School cost	0	17,544,309	0.000000	0	0	91.00
92.00	Allied health cost	0	17,544,309	0.000000	0	0	92.00
93.00	All other Medical Education	0	17,544,309	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/15/2015 7:44 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,949,052		30.00
35.00	02400 CHILDRENS		0		35.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.000000	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950 PARTIAL HOSPITAL	0.169959	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/15/2015 7:44 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		3,781,496		30.00
35.00	02400 CHILDRENS		12,828,457		35.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.000000	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950 PARTIAL HOSPITAL	0.169959	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/15/2015 7:44 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		140,226	2.00
3.00	PPS payments		279,006	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		279,006	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		57,913	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)		221,093	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)		221,093	30.00
31.00	Primary payer payments		2,570	31.00
32.00	Subtotal (line 30 minus line 31)		218,523	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		49,694	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		32,301	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		37,876	36.00
37.00	Subtotal (see instructions)		250,824	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)		250,824	40.00
40.01	Sequestration adjustment (see instructions)		5,016	40.01
41.00	Interim payments		214,150	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		31,658	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 144005		Period: From 01/01/2014 To 12/31/2014		Worksheet E-1 Part I Date/Time Prepared: 5/15/2015 7:44 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,346,199		214,150		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	12/31/2014	19,200		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		19,200		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)		4,365,399		214,150		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		31,658		6.01
6.02	SETTLEMENT TO PROGRAM		114,797		0		6.02
7.00	Total Medicare program liability (see instructions)		4,250,602		245,808		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		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/15/2015 7:44 am
		Title XVII	Hospital	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			4,652,105 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			75.745205 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			4,652,105 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			4,652,105 16.00
17.00	Primary payer payments			17,432 17.00
18.00	Subtotal (line 16 less line 17).			4,634,673 18.00
19.00	Deductibles			352,416 19.00
20.00	Subtotal (line 18 minus line 19)			4,282,257 20.00
21.00	Coinsurance			143,728 21.00
22.00	Subtotal (line 20 minus line 21)			4,138,529 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			309,725 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			201,321 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			199,498 25.00
26.00	Subtotal (sum of lines 22 and 24)			4,339,850 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	NON SPECIFIED ADJUSTMENT			-2,501 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			4,337,349 31.00
31.01	Sequestration adjustment (see instructions)			86,747 31.01
32.00	Interim payments			4,365,399 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			-114,797 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144005	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/15/2015 7:44 am
		Title XIX	Hospital	Cost
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	8,201,681		1.00
2.00	Medical and other services		227,279	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	8,201,681	227,279	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	8,201,681	227,279	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	16,609,953		8.00
9.00	Ancillary service charges	0	1,337,257	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	16,609,953	1,337,257	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	16,609,953	1,337,257	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	8,408,272	1,109,978	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	8,201,681	227,279	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	8,201,681	227,279	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	8,201,681	227,279	31.00
32.00	Deductibles	0		32.00
33.00	Coinurance	0		33.00
34.00	Allowable bad debts (see instructions)	0		34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	8,201,681	227,279	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		37.00
38.00	Subtotal (line 36 ± line 37)	8,201,681	227,279	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	8,201,681	227,279	40.00
41.00	Interim payments	8,201,681	227,279	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 144005

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

Worksheet G

Date/Time Prepared:
5/15/2015 7:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	819,282	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,672,551	0	0	0	4.00
5.00	Other receivable	3,584,663	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	157,988	0	0	0	7.00
8.00	Prepaid expenses	252,963	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,487,447	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,576,595	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,576,595	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	373,005	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	373,005	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,437,047	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,965,800	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,965,800	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,619,354	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,619,354	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,585,154	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	12,851,893	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)	12,851,893	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,437,047	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144005

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

Worksheet G-1

Date/Time Prepared:
5/15/2015 7:44 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		20,662,254		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,531,135			2.00
3.00	Total (sum of line 1 and line 2)		26,193,389		0	3.00
4.00	PAID IN CAPITAL	1,073,680		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1,073,680		0	10.00
11.00	Subtotal (line 3 plus line 10)		27,267,069		0	11.00
12.00	DISTRIBUTION OF EARNINGS	14,415,176		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)		14,415,176		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,851,893		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	PAID IN CAPITAL		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	DISTRIBUTION OF EARNINGS		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: 144005

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/15/2015 7:44 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	36,674,125		36,674,125	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	113,885		113,885	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	36,788,010		36,788,010	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	CHILDRENS	18,047,375		18,047,375	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	18,047,375		18,047,375	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	54,835,385		54,835,385	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	7,850,120	7,850,120	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MD REVENUE	1,095,012	0	1,095,012	27.00
27.01	SNAP REVENUE	824,240	0	824,240	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	56,754,637	7,850,120	64,604,757	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,836,585		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)		31,836,585		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144005

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

Worksheet G-3

Date/Time Prepared:
5/15/2015 7:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,604,757	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,340,917	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,263,840	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,836,585	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,427,255	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	179	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHR NON OPERATING REVENUE	2,103,701	24.00
25.00	Total other income (sum of lines 6-24)	2,103,880	25.00
26.00	Total (line 5 plus line 25)	5,531,135	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)	5,531,135	29.00