

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: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/25/2014 2:35 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/25/2014 Time: 2:35 pm	
	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 ALEXIAN BROTHERS BEHAVIORAL HEALTH (144031) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	107,334	29,198	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	107,334	29,198	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: 144031		Period: From 07/01/2013 To 06/30/2014		Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 2:34 pm			
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1650 MOON LAKE BOULEVARD		PO Box:				1.00		
2.00	City: HOFFMAN ESTATES		State: IL		Zip Code: 60194-		County: COOK		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
				2.00	3.00	4.00	5.00	6.00	7.00 8.00
		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		ALEXIAN BROTHERS BEHAVIORAL HEALTH		144031	16974	4	06/28/1990	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2013	06/30/2014	
21.00	Type of Control (see instructions)						1		21.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N	
22.01	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)								
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	N	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0
							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

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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 Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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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		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

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	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
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. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			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 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00

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		V	XIX		
		1.00	2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		
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		
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,004,949	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
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
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		
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		
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	149019	

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ALEXIAN BROTHERS HOSPITAL NETWORK	Contractor's Name: WPS		Contractor's Number: 05901			
142.00	Street: 3040 SALT CREEK LANE	PO Box:					
143.00	City: ARLINGTON HEIGHTS	State: IL	Zip Code: 60005				
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00	
				1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
165.00	Multi campus 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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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						
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				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	168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.00	169.00	
				Beginni ng 1.00	Endi ng 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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/25/2014 2:34 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/04/2014	Y	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: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/25/2014 2:34 pm
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	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.	1.00 N	2.00	3.00 N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?	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	06/30/2014		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.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY	LEONE		41.00
42.00	Enter the employer/company name of the cost report preparer.	LEONE REIMBURSEMENT&CONSULTING			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM		43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		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)	11/04/2014	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
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.	CPA	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: 144031

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	141	51,465	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)		141	51,465	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 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		141	51,465	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		141				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: 144031

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	17,565	3,735	47,386			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)	17,565	3,735	47,386			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	17,565	3,735	47,386	0.00	550.53	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	550.53	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: 144031

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

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	1,365	392	6,039	1.00	
2.00 HMO and other (see instructions)			0	0		2.00	
3.00 HMO IPF Subprovider						3.00	
4.00 HMO IRF Subprovider						4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00	
6.00 Hospital Adults & Peds. Swing Bed NF						6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00	
8.00 INTENSIVE CARE UNIT						8.00	
9.00 CORONARY CARE UNIT						9.00	
10.00 BURN INTENSIVE CARE UNIT						10.00	
11.00 SURGICAL INTENSIVE CARE UNIT						11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00 NURSERY						13.00	
14.00 Total (see instructions)	0.00	0	1,365	392	6,039	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)						24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	
27.00 Total (sum of lines 14-26)	0.00					27.00	
28.00 Observation Bed Days						28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01	
33.00 LTCH non-covered days						33.00	

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 144031		Period: From 07/01/2013 To 06/30/2014		Worksheet S-3 Part II Date/Time Prepared: 11/25/2014 2:34 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	35,592,917	0	35,592,917	1,145,106.00	31.08	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		199,134	0	199,134	2,080.00	95.74	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		1,164,319	0	1,164,319	8,355.00	139.36	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		9,967,487	0	9,967,487	235,270.00	42.37	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		1,316,276	0	1,316,276	24,112.00	54.59	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		6,048,396	0	6,048,396	106,054.00	57.03	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		5,772,918	0	5,772,918			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,677,608	0	1,677,608			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	-159,179	0	-159,179	0.00	0.00	26.00
27.00	Administrative & General	5.00	6,292,988	0	6,292,988	190,089.00	33.11	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	176,843	0	176,843	7,505.00	23.56	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	63,634	0	63,634	3,477.00	18.30	32.00
33.00	Housekeeping under contract (see instructions)		594,974	0	594,974	36,617.00	16.25	33.00
34.00	Dietary	10.00	251,785	-50,902	200,883	7,519.00	26.72	34.00
35.00	Dietary under contract (see instructions)		1,046,938	0	1,046,938	88,867.00	11.78	35.00
36.00	Cafeteria	11.00	0	50,902	50,902	1,905.00	26.72	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,183,354	0	1,183,354	34,189.00	34.61	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 144031

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

Worksheet S-3
Part II
Date/Time Prepared:
11/25/2014 2:34 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 444,164	0	444,164	18,464.00	24.06	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 144031

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

Worksheet S-3
Part III
Date/Time Prepared:
11/25/2014 2:34 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	36,070,510	0	36,070,510	1,262,235.00	28.58	1.00
2.00	Excluded area salaries (see instructions)	9,967,487	0	9,967,487	235,270.00	42.37	2.00
3.00	Subtotal salaries (line 1 minus line 2)	26,103,023	0	26,103,023	1,026,965.00	25.42	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,364,672	0	7,364,672	130,166.00	56.58	4.00
5.00	Subtotal wage-related costs (see inst.)	5,772,918	0	5,772,918	0.00	22.12	5.00
6.00	Total (sum of lines 3 thru 5)	39,240,613	0	39,240,613	1,157,131.00	33.91	6.00
7.00	Total overhead cost (see instructions)	9,895,501	0	9,895,501	388,632.00	25.46	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 11/25/2014 2:34 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			389,812 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			569,172 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			3,352,122 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			215,103 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			81,349 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			102,569 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			309,420 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			2,358,796 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			18,542 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			53,641 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			7,450,526 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part V Date/Time Prepared: 11/25/2014 2:34 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		1,316,276	7,450,526
2.00	Hospital		1,316,276	7,450,526
3.00	Subprovider - IPF			
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0
18.00	Other		0	0

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144031

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

Worksheet A
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		973,971	973,971	689,501	1,663,472	1.00
2.00	00200		0	0	264,281	264,281	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	-159,179	4,595,546	4,436,367	0	4,436,367	4.00
5.00	00500	6,292,988	19,239,621	25,532,609	-670,841	24,861,768	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	176,843	1,086,159	1,263,002	-98,594	1,164,408	7.00
8.00	00800	0	0	0	200,000	200,000	8.00
9.00	00900	63,634	918,911	982,545	-200,000	782,545	9.00
10.00	01000	251,785	1,749,048	2,000,833	-404,498	1,596,335	10.00
11.00	01100	0	0	0	404,498	404,498	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	1,183,354	124,663	1,308,017	0	1,308,017	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	444,164	368,785	812,949	0	812,949	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	13,680,096	2,542,387	16,222,483	356,293	16,578,776	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	18,877	18,877	250	19,127	54.00
60.00	06000	0	513,530	513,530	34,083	547,613	60.00
62.30	06250	0	0	0	0	0	62.30
66.00	06600	121,225	9,139	130,364	2,675	133,039	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	1,577,963	1,577,963	39,476	1,617,439	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	312,514	104,645	417,159	860	418,019	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	3,258,006	383,584	3,641,590	213,747	3,855,337	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		835,000	835,000	-835,000	0	113.00
118.00		25,625,430	35,041,829	60,667,259	-3,269	60,663,990	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	1,465,309	638,402	2,103,711	3,054	2,106,765	191.00
192.00	19200	7,757,247	1,290,809	9,048,056	0	9,048,056	192.00
194.00	07950	60,104	5,718	65,822	215	66,037	194.00
194.01	07951	684,827	90,527	775,354	0	775,354	194.01
200.00		35,592,917	37,067,285	72,660,202	0	72,660,202	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144031

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

Worksheet A
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	653,477	2,316,949	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	261,239	525,520	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	31,739	4,468,106	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,860,232	23,001,536	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	988,927	2,153,335	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	200,000	8.00
9.00	00900	HOUSEKEEPING	0	782,545	9.00
10.00	01000	DIETARY	0	1,596,335	10.00
11.00	01100	CAFETERIA	-185,363	219,135	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,308,017	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,640	829,589	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	16,578,776	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,127	54.00
60.00	06000	LABORATORY	0	547,613	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	133,039	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,617,439	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	-71,300	346,719	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	PARTIAL HOSPITALIZATION	-74,849	3,780,488	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-239,722	60,424,268	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	RESEARCH	-208,671	1,898,094	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-1,038,481	8,009,575	192.00
194.00	07950	DUI PROGRAM	0	66,037	194.00
194.01	07951	IPPS	-10,545	764,809	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,497,419	71,162,783	200.00

RECLASSIFICATIONS

Provider CCN: 144031

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

Worksheet A-6

Date/Time Prepared:
11/25/2014 2:34 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTAL EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	111,648	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS			0	111,648	
B - BUILDING RENTAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,134	1.00
2.00		0.00	0	0	2.00
TOTALS			0	7,134	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	50,902	353,596	1.00
TOTALS			50,902	353,596	
D - PFS RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	357,795	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	250	2.00
3.00	LABORATORY	60.00	0	34,083	3.00
4.00	PHYSICAL THERAPY	66.00	0	2,675	4.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	39,476	6.00
7.00	ELECTROSHOCK THERAPY	76.00	0	12,412	7.00
8.00	PARTIAL HOSPITALIZATION	93.00	0	214,300	8.00
9.00	RESEARCH	191.00	0	3,054	9.00
10.00	DUI PROGRAM	194.00	0	215	10.00
TOTALS			0	664,260	
E - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	200,000	1.00
TOTALS			0	200,000	
F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	835,000	1.00
TOTALS			0	835,000	
H - EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	264,281	1.00
TOTALS			0	264,281	
500.00	Grand Total: Increases		50,902	2,435,919	500.00

RECLASSIFICATIONS

Provider CCN: 144031

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

Worksheet A-6

Date/Time Prepared:
11/25/2014 2:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENTAL EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	98,594	10		1.00
2.00	ELECTROSHOCK THERAPY	76.00	0	11,552	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,502	0		3.00
	TOTALS		0	111,648			
B - BUILDING RENTAL							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,581	10		1.00
2.00	PARTIAL HOSPITALIZATION	93.00	0	553	0		2.00
	TOTALS		0	7,134			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	50,902	353,596	0		1.00
	TOTALS		50,902	353,596			
D - PFS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	664,260	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	TOTALS		0	664,260			
E - LAUNDRY							
1.00	HOUSEKEEPING	9.00	0	200,000	0		1.00
	TOTALS		0	200,000			
F - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	835,000	11		1.00
	TOTALS		0	835,000			
H - EQUIPMENT DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	264,281	9		1.00
	TOTALS		0	264,281			
500.00	Grand Total: Decreases		50,902	2,435,919			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144031

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

Worksheet A-7
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

		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	1,540,000	60,152	0	60,152	0	1.00
2.00	Land Improvements	32,989	0	0	0	16,990	2.00
3.00	Buildings and Fixtures	21,305,100	0	0	0	0	3.00
4.00	Building Improvements	615,666	725,292	0	725,292	52,819	4.00
5.00	Fixed Equipment	210,311	51,564	0	51,564	0	5.00
6.00	Movable Equipment	1,573,596	377,841	0	377,841	39,150	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,277,662	1,214,849	0	1,214,849	108,959	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,277,662	1,214,849	0	1,214,849	108,959	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,600,152	0				1.00
2.00	Land Improvements	15,999	0				2.00
3.00	Buildings and Fixtures	21,305,100	0				3.00
4.00	Building Improvements	1,288,139	0				4.00
5.00	Fixed Equipment	261,875	0				5.00
6.00	Movable Equipment	1,912,287	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	26,383,552	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	26,383,552	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144031

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

Worksheet A-7
Part II
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	973,971	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)	973,971	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	973,971				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	973,971				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144031

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

Worksheet A-7
Part III
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	24,471,266	0	24,471,266	0.927520	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,912,286	0	1,912,286	0.072480	0	2.00
3.00	Total (sum of lines 1-2)	26,383,552	0	26,383,552	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,102,239	118,782	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	525,520	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,627,759	118,782	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	95,928	0	0	0	2,316,949	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	525,520	2.00
3.00	Total (sum of lines 1-2)	95,928	0	0	0	2,842,469	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144031

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

Worksheet A-8

Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-739,072	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	3,171,951			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-185,363	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-807	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-17,848	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	102,886	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 MISC INCOME	B	-19,095	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 BAD DEBTS	A	-1,737,642	ADMINISTRATIVE & GENERAL	5.00	0	33.01

Provider CCN: 144031
 Period: From 07/01/2013 To 06/30/2014
 Worksheet A-8
 Date/Time Prepared: 11/25/2014 2:34 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.02 RESEARCH HBP	A	-151,277	RESEARCH	191.00	0	33.02
33.03 GROUP PRACTICE HBP	A	-825,594	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.03
33.05 PHYSICIAN GUARANTEE	A	-21,241	ADMINISTRATIVE & GENERAL	5.00	0	33.05
34.00 BUSINESS DEVELOPMENT/MARKETING	A	-319,649	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 BUSINESS DEVELOPMENT OTHER INCO	B	-82,551	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 ELECT OTHER INCOME	B	-71,300	ELECTROSHOCK THERAPY	76.00	0	36.00
37.00 SCHOOL REIMBURSEMENT	A	-524,928	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 OTHER INCOME - AFTERCARE	B	-51,440	PARTIAL HOSPITALIZATION	93.00	0	38.00
39.00 REAL ESTATE TAXES	A	-9,000	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00		0		0.00	0	40.00
40.01 MANAGEMENT FEE NON I/C	B	-9,360	ADMINISTRATIVE & GENERAL	5.00	0	40.01
40.02 GAIN ON SALE ME	A	-89	CAP REL COSTS-MVBLE EQUIP	2.00	9	40.02
40.03 DONATIONS	A	-6,000	ADMINISTRATIVE & GENERAL	5.00	0	40.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,497,419				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: 144031

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

Worksheet A-8-1

Date/Time Prepared:
11/25/2014 2:34 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ABHN NON CAP	9,905,847	9,017,903 1.00
2.00	0.00		0	0	0 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	26,237	0 3.00
3.01	16.00	MEDICAL RECORDS & LIBRARY	ICD 10 TRAINING	17,447	0 3.01
3.02	1.00	CAP REL COSTS-BLDG & FIXT	ABHN CAPITAL	1,371,572	0 3.02
3.03	2.00	CAP REL COSTS-MVBLE EQUIP	ABHN CAPITAL	158,442	0 3.03
3.04	7.00	OPERATION OF PLANT	CLINICAL ENGINEERING	999,802	10,875 3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	EXECUTIVE SALARIES	945,438	945,438 3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	EXECUTIVE BENEFITS	218,881	187,142 3.06
3.07	1.00	CAP REL COSTS-BLDG & FIXT	ABMP CAPITAL	38,825	0 3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	ABMP NON CAPITAL	5,442	50,389 3.08
3.09	93.00	PARTIAL HOSPITALIZATION	ABMP NON CAPITAL	0	23,409 3.09
3.10	191.00	RESEARCH	ABMP NON CAPITAL	86,033	143,427 3.10
3.11	192.00	PHYSICIANS' PRIVATE OFFICES	ABMP NON CAPITAL	319,122	532,009 3.11
3.12	194.01	PPS	ABMP NON CAPITAL	15,807	26,352 3.12
3.13	0.00			0	0 3.13
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,108,895	10,936,944 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	ABHS	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:			0.00	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: 144031

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

Worksheet A-8-2

Date/Time Prepared:
11/25/2014 2:34 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	DR. A	199,134	0	199,134	200,000	2,080	1.00
2.00	0.00		0	0	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			199,134	0	199,134		2,080	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	DR. A	200,000	10,000	0	0	0	1.00
2.00	0.00		0	0	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			200,000	10,000	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	5.00	DR. A	0	200,000	0	0		1.00
2.00	0.00		0	0	0	0		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	200,000	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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

Worksheet B
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,316,949	2,316,949			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	525,520		525,520		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,468,106	0	0	4,468,106	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	23,001,536	713,854	161,913	786,466	24,663,769
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	2,153,335	10,868	2,465	22,101	2,188,769
8.00 00800	LAUNDRY & LINEN SERVICE	200,000	4,824	1,094	0	205,918
9.00 00900	HOUSEKEEPING	782,545	2,713	615	7,953	793,826
10.00 01000	DIETARY	1,596,335	30,439	6,904	25,105	1,658,783
11.00 01100	CAFETERIA	219,135	49,208	11,161	6,361	285,865
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	1,308,017	0	0	147,890	1,455,907
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	829,589	19,407	4,402	55,509	908,907
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	16,578,776	1,086,839	246,511	1,709,660	19,621,786
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	19,127	0	0	0	19,127
60.00 06000	LABORATORY	547,613	0	0	0	547,613
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
66.00 06600	PHYSICAL THERAPY	133,039	0	0	15,150	148,189
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,617,439	8,283	1,879	0	1,627,601
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	346,719	11,214	2,544	39,056	399,533
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
93.00 04950	PARTIAL HOSPITALIZATION	3,780,488	101,001	22,909	407,169	4,311,567
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	60,424,268	2,038,650	462,397	3,222,420	58,837,160
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	1,898,094	3,750	851	183,127	2,085,822
192.00 19200	PHYSICIANS' PRIVATE OFFICES	8,009,575	274,549	62,272	969,462	9,315,858
194.00 07950	DUI PROGRAM	66,037	0	0	7,511	73,548
194.01 07951	I PPS	764,809	0	0	85,586	850,395
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118-201)	71,162,783	2,316,949	525,520	4,468,106	71,162,783

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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

Worksheet B
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
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	24,663,769				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	1,160,956	0	3,349,725		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	109,222	0	10,149	325,289	8.00
9.00	00900	HOUSEKEEPING	421,057	0	5,707	0	1,220,590
10.00	01000	DIETARY	879,843	0	64,037	0	23,445
11.00	01100	CAFETERIA	151,627	0	103,524	0	37,902
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	772,235	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	482,098	0	40,827	0	14,948
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,407,685	0	2,286,489	325,289	837,124
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,145	0	0	0	0
60.00	06000	LABORATORY	290,462	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	78,602	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	863,304	0	17,426	0	6,380
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03320	ELECTROSHOCK THERAPY	211,918	0	23,593	0	8,638
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04950	PARTIAL HOSPITALIZATION	2,286,920	0	212,486	0	77,795
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,126,074	0	2,764,238	325,289	1,006,232
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	1,106,351	0	7,890	0	2,889
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,941,271	0	577,597	0	211,469
194.00	07950	DUI PROGRAM	39,011	0	0	0	0
194.01	07951	IPPS	451,062	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	24,663,769	0	3,349,725	325,289	1,220,590

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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

Worksheet B
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	2,626,108					10.00
11.00	01100		578,918				11.00
12.00	01200			0			12.00
13.00	01300		21,181		2,249,323		13.00
14.00	01400					0	14.00
15.00	01500					0	15.00
16.00	01600		11,441			0	16.00
17.00	01700					0	17.00
19.00	01900					0	19.00
20.00	02000					0	20.00
21.00	02100					0	21.00
22.00	02200					0	22.00
23.00	02300					0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,626,108	310,987	0	1,729,182	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
66.00	06600	0	1,933	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	0	6,107	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	0	81,541	0	520,141	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,626,108	433,190	0	2,249,323	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	16,272	0	0	0	191.00
192.00	19200	0	108,687	0	0	0	192.00
194.00	07950	0	1,250	0	0	0	194.00
194.01	07951	0	19,519	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,626,108	578,918	0	2,249,323	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
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
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600	0	1,458,221				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	789,308	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	551	0	0	0	54.00
60.00	06000	0	75,195	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
66.00	06600	0	5,902	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	87,093	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	0	27,384	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	0	472,788	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		0	1,458,221	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		0	1,458,221	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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To 06/30/2014

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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
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
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	38,933,958	0 30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,823	0 54.00
60.00 06000	LABORATORY	0	0	0	913,270	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
66.00 06600	PHYSICAL THERAPY	0	0	0	234,626	0 66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,601,804	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03320	ELECTROSHOCK THERAPY	0	0	0	677,173	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	0	0	7,963,238	0 93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	51,353,892	0 118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	0	0	0	3,219,224	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	15,154,882	0 192.00
194.00 07950	DUI PROGRAM	0	0	0	113,809	0 194.00
194.01 07951	IPPS	0	0	0	1,320,976	0 194.01
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	0	0	71,162,783	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

Period:
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Cost Center Description		Total	
		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
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03320	ELECTROSHOCK THERAPY	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04950	PARTIAL HOSPITALIZATION	93.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	DUI PROGRAM	194.00
194.01	07951	IPPS	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144031

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	713,854	161,913	875,767	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	10,868	2,465	13,333	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,824	1,094	5,918	8.00
9.00 00900	HOUSEKEEPING	0	2,713	615	3,328	9.00
10.00 01000	DIETARY	0	30,439	6,904	37,343	10.00
11.00 01100	CAFETERIA	0	49,208	11,161	60,369	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	19,407	4,402	23,809	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,086,839	246,511	1,333,350	30.00
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
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	8,283	1,879	10,162	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0	11,214	2,544	13,758	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	101,001	22,909	123,910	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,038,650	462,397	2,501,047	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	0	3,750	851	4,601	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	274,549	62,272	336,821	192.00
194.00 07950	DUI PROGRAM	0	0	0	0	194.00
194.01 07951	IPPS	0	0	0	0	194.01
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)	0	2,316,949	525,520	2,842,469	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144031

Period:
From 07/01/2013
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	875,767					5.00
6.00	00600	0	0				6.00
7.00	00700	41,223	0	54,556			7.00
8.00	00800	3,878	0	165	9,961		8.00
9.00	00900	14,951	0	93	0	18,372	9.00
10.00	01000	31,242	0	1,043	0	353	10.00
11.00	01100	5,384	0	1,686	0	570	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	27,421	0	0	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	17,118	0	665	0	225	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	369,562	0	37,240	9,961	12,601	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	360	0	0	0	0	54.00
60.00	06000	10,314	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
66.00	06600	2,791	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	30,654	0	284	0	96	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	7,525	0	384	0	130	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	81,204	0	3,461	0	1,171	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		643,627	0	45,021	9,961	15,146	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	39,284	0	128	0	43	191.00
192.00	19200	175,455	0	9,407	0	3,183	192.00
194.00	07950	1,385	0	0	0	0	194.00
194.01	07951	16,016	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		875,767	0	54,556	9,961	18,372	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 144031		Period: From 07/01/2013 To 06/30/2014		Worksheet B Part II Date/Time Prepared: 11/25/2014 2:34 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	69,981					10.00
11.00	01100	CAFETERIA	0	68,009				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,488	0	29,909		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,344	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	69,981	36,534	0	22,993	0	30.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	227	0	0	0	66.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	717	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	9,579	0	6,916	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,981	50,889	0	29,909	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	1,912	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,768	0	0	0	192.00
194.00	07950	DUI PROGRAM	0	147	0	0	0	194.00
194.01	07951	IPPS	0	2,293	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	69,981	68,009	0	29,909	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 144031		Period: From 07/01/2013 To 06/30/2014		Worksheet B Part II Date/Time Prepared: 11/25/2014 2:34 pm	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	0					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43,161				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	23,359	0			30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16	0			54.00
60.00	06000	LABORATORY	0	2,226	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
66.00	06600	PHYSICAL THERAPY	0	175	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,578	0			73.00
74.00	07400	RENAL DIALYSIS	0	0	0			74.00
76.00	03320	ELECTROSHOCK THERAPY	0	811	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	13,996	0			93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0			94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	43,161	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	RESEARCH	0	0	0			191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
194.00	07950	DUI PROGRAM	0	0	0			194.00
194.01	07951	IPPS	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	43,161	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144031

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
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
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0			22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS			1,915,581		0 30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC			376	0	54.00
60.00 06000	LABORATORY			12,540	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	62.30
66.00 06600	PHYSICAL THERAPY			3,193	0	66.00
69.00 06900	ELECTROCARDIOLOGY			0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS			43,774	0	73.00
74.00 07400	RENAL DIALYSIS			0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY			23,325	0	76.00
76.97 07697	CARDIAC REHABILITATION			0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY			0	0	76.98
76.99 07699	LITHOTRIpsy			0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.00 04950	PARTIAL HOSPITALIZATION			240,237	0	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS			0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	2,239,026	0 118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH			45,968	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES			537,634	0	192.00
194.00 07950	DUI PROGRAM			1,532	0	194.00
194.01 07951	IPPS			18,309	0	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	0	2,842,469	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 11/25/2014 2:34 pm
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Cost Center Description		Total	
		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
6.00	00600	MAINTENANCE & REPAIRS	6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,915,581
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	376
60.00	06000	LABORATORY	12,540
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0
66.00	06600	PHYSICAL THERAPY	3,193
69.00	06900	ELECTROCARDIOLOGY	0
73.00	07300	DRUGS CHARGED TO PATIENTS	43,774
74.00	07400	RENAL DIALYSIS	0
76.00	03320	ELECTROSHOCK THERAPY	23,325
76.97	07697	CARDIAC REHABILITATION	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0
76.99	07699	LITHOTRIPSY	0
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	
93.00	04950	PARTIAL HOSPITALIZATION	240,237
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,239,026
NONREIMBURSABLE COST CENTERS			
191.00	19100	RESEARCH	45,968
192.00	19200	PHYSICIANS' PRIVATE OFFICES	537,634
194.00	07950	DUI PROGRAM	1,532
194.01	07951	IPPS	18,309
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118-201)	2,842,469

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1

Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	127,270				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		127,270			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	35,752,096		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	39,212	39,212	6,292,988	-24,663,769	46,499,014
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	597	597	176,843	0	2,188,769
8.00 00800	LAUNDRY & LINEN SERVICE	265	265	0	0	205,918
9.00 00900	HOUSEKEEPING	149	149	63,634	0	793,826
10.00 01000	DIETARY	1,672	1,672	200,883	0	1,658,783
11.00 01100	CAFETERIA	2,703	2,703	50,902	0	285,865
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	1,183,354	0	1,455,907
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	444,164	0	908,907
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	59,700	59,700	13,680,096	0	19,621,786
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	19,127
60.00 06000	LABORATORY	0	0	0	0	547,613
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
66.00 06600	PHYSICAL THERAPY	0	0	121,225	0	148,189
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	455	455	0	0	1,627,601
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03320	ELECTROSHOCK THERAPY	616	616	312,514	0	399,533
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00 04950	PARTIAL HOSPITALIZATION	5,548	5,548	3,258,006	0	4,311,567
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	111,983	111,983	25,784,609	-24,663,769	34,173,391
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	206	206	1,465,309	0	2,085,822
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,081	15,081	7,757,247	0	9,315,858
194.00 07950	DUI PROGRAM	0	0	60,104	0	73,548
194.01 07951	I PPS	0	0	684,827	0	850,395
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,316,949	525,520	4,468,106		24,663,769
203.00	Unit cost multiplier (Wkst. B, Part I)	18.204989	4.129174	0.124975		0.530415
204.00	Cost to be allocated (per Wkst. B, Part II)			0		875,767
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.018834

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1

Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	87,461			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	265	100		8.00
9.00	00900	HOUSEKEEPING	0	149	0	87,047	9.00
10.00	01000	DIETARY	0	1,672	0	1,672	142,158
11.00	01100	CAFETERIA	0	2,703	0	2,703	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,066	0	1,066	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	59,700	100	59,700	142,158
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	455	0	455	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03320	ELECTROSHOCK THERAPY	0	616	0	616	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	5,548	0	5,548	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	72,174	100	71,760	142,158
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	206	0	206	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,081	0	15,081	0
194.00	07950	DUI PROGRAM	0	0	0	0	0
194.01	07951	IPPS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	3,349,725	325,289	1,220,590	2,626,108
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	38.299642	3,252.890000	14.022195	18.473164
204.00		Cost to be allocated (per Wkst. B, Part II)	0	54,556	9,961	18,372	69,981
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.623775	99.610000	0.211058	0.492276

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1

Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		CAFETERIA (FULL TIME EQUIV'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	44,934					11.00
12.00	01200	0	0				12.00
13.00	01300	1,644	0	556,141			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	888	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	24,138	0	427,537	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
66.00	06600	150	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	474	0	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	6,329	0	128,604	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		33,623	0	556,141	0	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	1,263	0	0	0	0	191.00
192.00	19200	8,436	0	0	0	0	192.00
194.00	07950	97	0	0	0	0	194.00
194.01	07951	1,515	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		578,918	0	2,249,323	0	0	202.00
203.00		12.883741	0.000000	4.044519	0.000000	0.000000	203.00
204.00		68,009	0	29,909	0	0	204.00
205.00		1.513531	0.000000	0.053780	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1

Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
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
6.00 00600 MAINTENANCE & REPAIRS						6.00
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
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	141,539,116					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	76,614,980	0		0	0	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	53,464	0	0	0	0	54.00
60.00 06000 LABORATORY	7,298,357	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
66.00 06600 PHYSICAL THERAPY	572,891	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8,453,172	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03320 ELECTROSHOCK THERAPY	2,657,910	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00 04950 PARTIAL HOSPITALIZATION	45,888,342	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	141,539,116	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950 DUI PROGRAM	0	0	0	0	0	194.00
194.01 07951 IPPS	0	0	0	0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,458,221	0	0	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.010303	0.000000	0.000000	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	43,161	0	0	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000305	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	22.00	23.00	
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
6.00 00600	MAINTENANCE & REPAIRS		6.00
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
12.00 01200	MAINTENANCE OF PERSONNEL		12.00
13.00 01300	NURSING ADMINISTRATION		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY		14.00
15.00 01500	PHARMACY		15.00
16.00 01600	MEDICAL RECORDS & LIBRARY		16.00
17.00 01700	SOCIAL SERVICE		17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00 02000	NURSING SCHOOL		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 03000	ADULTS & PEDIATRICS	0	30.00
ANCILLARY SERVICE COST CENTERS			
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00 06000	LABORATORY	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
66.00 06600	PHYSICAL THERAPY	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00 07400	RENAL DIALYSIS	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99 07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS			
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	93.00
OTHER REIMBURSABLE COST CENTERS			
94.00 09400	HOME PROGRAM DIALYSIS	0	94.00
SPECIAL PURPOSE COST CENTERS			
113.00 11300	INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS			
191.00 19100	RESEARCH	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00 07950	DUI PROGRAM	0	194.00
194.01 07951	IPPS	0	194.01
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00

Provider CCN: 144031

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

Worksheet B-2
 Date/Time Prepared:
 11/25/2014 2:34 pm

	Description	Worksheet		Amount	
		Part	Line No.		
	1.00	2.00	3.00	4.00	
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS		1 74.00	0	1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM		1 94.00	0	2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1 74.00	0	3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM		1 94.00	0	4.00
5.00	ADJ FOR ESA COSTS IN RENAL DIALYSIS		1 74.00	0	5.00
6.00	ADJ FOR ESA COSTS IN HOME PROGRAM		1 94.00	0	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
				PPS			
				Total Costs	RCE Disallowance		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	38,933,958			0	38,933,958	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	29,823			0	29,823	54.00
60.00	06000 LABORATORY	913,270			0	913,270	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62.30
66.00	06600 PHYSICAL THERAPY	234,626	0		0	234,626	66.00
69.00	06900 ELECTROCARDIOLOGY	0			0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,601,804			0	2,601,804	73.00
74.00	07400 RENAL DIALYSIS	0			0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	677,173			0	677,173	76.00
76.97	07697 CARDIAC REHABILITATION	0			0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0			0	0	76.98
76.99	07699 LI THOTRI PSY	0			0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	7,963,238			0	7,963,238	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0			0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	51,353,892	0		0	51,353,892	200.00
201.00	Less Observation Beds	0			0	0	201.00
202.00	Total (see instructions)	51,353,892	0		0	51,353,892	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

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	76,614,980		76,614,980			30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,464	0	53,464	0.557815	0.000000	54.00
60.00	06000	LABORATORY	7,290,157	8,200	7,298,357	0.125134	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
66.00	06600	PHYSICAL THERAPY	572,891	0	572,891	0.409547	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,691,685	761,487	8,453,172	0.307790	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03320	ELECTROSHOCK THERAPY	1,466,860	1,191,050	2,657,910	0.254776	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	45,888,342	45,888,342	0.173535	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	93,690,037	47,849,079	141,539,116			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	93,690,037	47,849,079	141,539,116			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/25/2014 2:34 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.557815		54.00
60.00	06000 LABORATORY	0.125134		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
66.00	06600 PHYSICAL THERAPY	0.409547		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.307790		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03320 ELECTROSHOCK THERAPY	0.254776		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.173535		93.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
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: 144031

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

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	38,933,958		38,933,958	0	38,933,958 30.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	29,823		29,823	0	29,823 54.00	
60.00	06000 LABORATORY	913,270		913,270	0	913,270 60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30	
66.00	06600 PHYSICAL THERAPY	234,626	0	234,626	0	234,626 66.00	
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	2,601,804		2,601,804	0	2,601,804 73.00	
74.00	07400 RENAL DIALYSIS	0		0	0	0 74.00	
76.00	03320 ELECTROSHOCK THERAPY	677,173		677,173	0	677,173 76.00	
76.97	07697 CARDIAC REHABILITATION	0		0	0	0 76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98	
76.99	07699 LI THOTRI PSY	0		0	0	0 76.99	
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0 92.00	
93.00	04950 PARTIAL HOSPITALIZATION	7,963,238		7,963,238	0	7,963,238 93.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0 94.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						
200.00	Subtotal (see instructions)	51,353,892	0	51,353,892	0	51,353,892 200.00	
201.00	Less Observation Beds	0		0	0	0 201.00	
202.00	Total (see instructions)	51,353,892	0	51,353,892	0	51,353,892 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	76,614,980		76,614,980		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,464	0	53,464	0.557815	54.00
60.00	06000	LABORATORY	7,290,157	8,200	7,298,357	0.125134	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
66.00	06600	PHYSICAL THERAPY	572,891	0	572,891	0.409547	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,691,685	761,487	8,453,172	0.307790	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03320	ELECTROSHOCK THERAPY	1,466,860	1,191,050	2,657,910	0.254776	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	45,888,342	45,888,342	0.173535	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	93,690,037	47,849,079	141,539,116		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	93,690,037	47,849,079	141,539,116		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/25/2014 2:34 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03320 ELECTROSHOCK THERAPY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
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: 144031		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part I Date/Time Prepared: 11/25/2014 2:34 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,915,581	0	1,915,581	47,386	40.43	30.00
200.00	Total (Lines 30-199)	1,915,581		1,915,581	47,386		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	17,565	710,153				
200.00	Total (Lines 30-199)	17,565	710,153				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Prepared: 11/25/2014 2:34 pm			
Cost Center Description			Title XVIII		Hospital	PPS		
			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	376	53,464	0.007033	41,290	290	54.00
60.00	06000	LABORATORY	12,540	7,298,357	0.001718	2,710,634	4,657	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
66.00	06600	PHYSICAL THERAPY	3,193	572,891	0.005573	503,307	2,805	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,774	8,453,172	0.005178	3,991,068	20,666	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	23,325	2,657,910	0.008776	907,323	7,963	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	240,237	45,888,342	0.005235	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	323,445	64,924,136		8,153,622	36,381	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144031		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part III Date/Time Prepared: 11/25/2014 2:34 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS 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
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	47,386	0.00	17,565	0	0	30.00
200.00		Total (lines 30-199)	47,386		17,565	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144031

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144031

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,464	0.000000	0.000000	41,290	54.00
60.00	06000	LABORATORY	0	7,298,357	0.000000	0.000000	2,710,634	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
66.00	06600	PHYSICAL THERAPY	0	572,891	0.000000	0.000000	503,307	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,453,172	0.000000	0.000000	3,991,068	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	2,657,910	0.000000	0.000000	907,323	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	45,888,342	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	0	64,924,136			8,153,622	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144031

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	284,673	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03320 ELECTROSHOCK THERAPY	0	616,332	0		76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04950 PARTIAL HOSPITALIZATION	0	1,870,491	0		93.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0		94.00
200.00	Total (Lines 50-199)	0	2,771,496	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/25/2014 2:34 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.557815	0	0	0	0	54.00
60.00	06000	LABORATORY	0.125134	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
66.00	06600	PHYSICAL THERAPY	0.409547	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.307790	284,673	0	0	87,620	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0.254776	616,332	0	0	157,027	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0.173535	1,870,491	0	0	324,596	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00		Subtotal (see instructions)		2,771,496	0	0	569,243	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,771,496	0	0	569,243	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/25/2014 2:34 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00 06000	LABORATORY	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
66.00 06600	PHYSICAL THERAPY	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400	HOME PROGRAM DIALYSIS	0	0	94.00
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/25/2014 2:34 pm
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)		47,386	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		47,386	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)		47,386	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)		17,565	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)		38,933,958	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)		38,933,958	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)		38,933,958	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)		821.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,431,931	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)		14,431,931	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/25/2014 2:34 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				2,027,927	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				16,459,858	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)				710,153	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				36,381	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				746,534	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				15,713,324	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: 144031

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

Worksheet D-1

Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description	Cost	Title XVIII		Hospital	PPS	
		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	1,915,581	38,933,958	0.049201	0	0	90.00
91.00 Nursing School cost	0	38,933,958	0.000000	0	0	91.00
92.00 Allied health cost	0	38,933,958	0.000000	0	0	92.00
93.00 All other Medical Education	0	38,933,958	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/25/2014 2:34 pm
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)		47,386	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		47,386	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)		47,386	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)		3,735	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)		38,933,958	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)		38,933,958	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)		38,933,958	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)		821.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,068,788	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)		3,068,788	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/25/2014 2:34 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00
42.00	Intensive Care Type Inpatient Hospital Units					42.00
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,068,788 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: 144031		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/25/2014 2:34 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,915,581	38,933,958	0.049201	0	0	90.00
91.00	Nursing School cost	0	38,933,958	0.000000	0	0	91.00
92.00	Allied health cost	0	38,933,958	0.000000	0	0	92.00
93.00	All other Medical Education	0	38,933,958	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/25/2014 2:34 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		28,591,642		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.557815	41,290	23,032	54.00
60.00	06000 LABORATORY	0.125134	2,710,634	339,192	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
66.00	06600 PHYSICAL THERAPY	0.409547	503,307	206,128	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.307790	3,991,068	1,228,411	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	0.254776	907,323	231,164	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.173535	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50-94 and 96-98)		8,153,622	2,027,927	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)		8,153,622		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/25/2014 2:34 pm
		Title XVII	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)		569,243	2.00
3.00	PPS payments		748,117	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 Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		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 Worksheet D-4, Part 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)		748,117	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)		150,165	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		597,952	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		597,952	30.00
31.00	Primary payer payments		37	31.00
32.00	Subtotal (line 30 minus line 31)		597,915	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		45,844	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		29,799	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,808	36.00
37.00	Subtotal (see instructions)		627,714	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		627,714	40.00
40.01	Sequestration adjustment (see instructions)		12,554	40.01
41.00	Interim payments		585,962	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		29,198	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: 144031

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

Worksheet E-1
Part I
Date/Time Prepared:
11/25/2014 2:34 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		13,805,935		585,962		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		145,049		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		13,950,984		585,962		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		107,334		29,198		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		14,058,318		615,160		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: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part II Date/Time Prepared: 11/25/2014 2:34 pm
		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)		15,063,623	1.00
2.00	Net IPF PPS Outlier Payments		10,070	2.00
3.00	Net IPF PPS ECT Payments		264,729	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 §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 inst.)		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 inst.)		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)		129.824658	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)		15,338,422	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)		15,338,422	16.00
17.00	Primary payer payments		12,544	17.00
18.00	Subtotal (line 16 less line 17).		15,325,878	18.00
19.00	Deductibles		907,424	19.00
20.00	Subtotal (line 18 minus line 19)		14,418,454	20.00
21.00	Coinsurance		330,696	21.00
22.00	Subtotal (line 20 minus line 21)		14,087,758	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		396,098	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		257,464	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		42,359	25.00
26.00	Subtotal (sum of lines 22 and 24)		14,345,222	26.00
27.00	Direct graduate medical education payments (from Worksheet 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	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		14,345,222	31.00
31.01	Sequestration adjustment (see instructions)		286,904	31.01
32.00	Interim payments		13,950,984	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		107,334	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		10,070	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: 144031	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2014 2: 34 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		3,068,788		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,068,788	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,068,788	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		3,068,788	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		3,068,788	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 144031 Period: From 07/01/2013 To 06/30/2014 Worksheet G
 Date/Time Prepared: 11/25/2014 2:34 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,915,000	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	8,872,000	0	0	0	4.00
5.00	Other receivable	-552	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	111,000	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	460,000	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)	15,357,448	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,540,000	0	0	0	12.00
13.00	Land improvements	76,152	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	21,305,100	0	0	0	15.00
16.00	Accumulated depreciation	-2,355,000	0	0	0	16.00
17.00	Leasehold improvements	1,288,139	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	261,875	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,912,286	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)	24,028,552	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,386,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,079,000	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	8,088,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,167,000	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	1,783,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,783,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,950,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	26,436,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	26,436,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,386,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144031

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

Worksheet G-1

Date/Time Prepared:
11/25/2014 2:34 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		21,214,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		6,316,000			2.00
3.00	Total (sum of line 1 and line 2)		27,530,000		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		27,530,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	TRANSFERS TO AFFILIATES	1,094,000		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)		1,094,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		26,436,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	TRANSFERS TO AFFILIATES		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: 144031

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2014 2:34 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	76,614,980		76,614,980	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	76,614,980		76,614,980	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	76,614,980		76,614,980	17.00
18.00	Ancillary services	17,075,057	1,960,737	19,035,794	18.00
19.00	Outpatient services	0	45,888,342	45,888,342	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	RESEARCH	653,970	0	653,970	27.00
27.01	PHYSICIAN PRIVATE OFFICE	0	15,264,253	15,264,253	27.01
27.02	OTHER NRCC	0	46,073	46,073	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	94,344,007	63,159,405	157,503,412	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		72,660,202		29.00
30.00	ROUNDING	1,961			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)		1,961		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)		72,662,163		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144031

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

Worksheet G-3

Date/Time Prepared:
11/25/2014 2:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	157,503,412	1.00
2.00	Less contractual allowances and discounts on patients' accounts	84,711,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	72,792,412	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	72,662,163	4.00
5.00	Net income from service to patients (line 3 minus line 4)	130,249	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,250	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	185,363	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	807	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	CAPITATION REVENUE	602,000	24.00
24.01	SCHOOL EDUCATION REIMBURSEMENT	1,289,360	24.01
24.02	BUSINESS DEVELOPMENT	117,185	24.02
24.03	RESTRICTED FUNDS	223,323	24.03
24.04	CLINICAL RESEARCH	2,124,834	24.04
24.05	MISC REVENUE	51,440	24.05
24.06	IPPS REVENUE	346,848	24.06
24.07	ABMP PROFESSIONAL FEES	190,095	24.07
24.08	INTERNS AND RESIDENTS	0	24.08
24.09	INTAKE	354,854	24.09
24.10	ECT PUBLIC AID	71,300	24.10
24.11	PATIENT ACCOUNTS	144,317	24.11
24.12	SAFE PROGRAM	15,975	24.12
24.13	EDUCATION	6,765	24.13
24.14	OTHER FEES	9,360	24.14
24.15	COMMUNITY ACTIVITY	14,096	24.15
24.16	DONATED SERVICES	436,490	24.16
24.17	GAIN ON SALE M/E	89	24.17
25.00	Total other income (sum of lines 6-24)	6,185,751	25.00
26.00	Total (line 5 plus line 25)	6,316,000	26.00
27.00	RECONCILING AMOUNT	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)	6,316,000	29.00