

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).
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
 Provider CCN: 150057
 Period: From 01/01/2014 To 12/31/2014
 Worksheet S Parts I-III
 Date/Time Prepared: 5/26/2015 5:30 pm
 OMB NO. 0938-0050

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.
 Date: 5/26/2015 Time: 5:30 pm

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. FRANCIS H&H-MOORESVILLE (150057) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/26/2015 Time: 5:30 pm
 hMDncsar0:Toe9Hq0BeAdcalk8XoQ0
 VekdC0bPo1JizCK9M4xccJCl:uBgGS
 ::CU1b.H2L0shF6p
 PI: Date: 5/26/2015 Time: 5:30 pm
 D1FEpp8c7XSJ4Dku15IH8qZ1EUgr:0
 SdzCb0C10EHwgwBkuPFJjvgCwe7oyM
 nTV.0t5uaz0PCQYZ

(Signed)

J. K. Fawcett

Officer or Administrator of Provider(s)

Regional CFO

Title

5/28/15

Date

	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	16,420	40,885	112,018	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	16,420	40,885	112,018	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: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 3:59 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1201 HADLEY ROAD	PO Box:							1.00	
2.00	City: MOORESVILLE	State: IN		Zip Code: 46158-		County: MORGAN			2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	V	XVIII	XIX	
3.00	Hospital and Hospital-Based Component Identification:									
	Hospital	ST. FRANCIS H&H-MOORESVILLE	150057	26900	1	07/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2014	12/31/2014		20.00	
21.00	Type of Control (see instructions)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 3:59 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0				35.00
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0				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.		0				38.00
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N		40.00	
		V	XIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.		N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N	48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		Y			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		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, § 2148? If yes, complete Wkst. D-5.		N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)		N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
				1.00			
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 Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N 63.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 1/ (col . 1 + col . 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col . 3/ (col . 3 + col . 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00	

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

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		V	XIX				
		1.00	2.00				
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y			90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y			91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N			92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N			93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N			94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00			95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N			96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00			97.00	
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N	110.00
						1.00	2.00
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, §2208.1.	N			0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2					118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	0	0			118.01	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N			120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 3:59 pm	
		1.00	2.00				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	158014			140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: FRANCISCAN ALLIANCE, INC. AND AFFILI	Contractor's Name: WISCONSIN PHYSICIAN S SERVICE		Contractor's Number: 08101			141.00
142.00	Street: 1515 W DRAGON TRL	PO Box: 1290					142.00
143.00	City: MISHAWAKA	State: IN	Zip Code: 46544				143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y				144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.		N				145.00
						1.00	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, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
161.10	CORF		N	N	N		161.10
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N		165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 3:59 pm
				1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			Y 167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0 168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.25 169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07/01/2014 09/30/2014 170.00
				1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/26/2015 3:59 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.	Y			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/02/2015	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: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/26/2015 3:59 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
		1.00	2.00	3.00	
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y	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.	BKD		BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-581-0435		LVCOSTREPORTS@BKD.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)	04/02/2015	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.	BKD	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: 150057

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2015 3:59 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps		
					Title V		
	1.00	2.00	3.00	4.00	5.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	88	32,120	0.00			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)		88	32,120	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	34.00	10	3,650	0.00		0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY	43.00					0	13.00
14.00 Total (see instructions)		98	35,770	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
25.10 CMHC - CORF	99.10					0	25.10
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)		98					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: 150057

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2015 3:59 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,632	241	7,714			1.00
2.00 HMO and other (see instructions)	1,234	812				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)	4,632	241	7,714			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	659	31	970			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		20	639			13.00
14.00 Total (see instructions)	5,291	292	9,323	0.38	352.86	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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.38	352.86	27.00
28.00 Observation Bed Days		57	535			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	32	61			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: 150057

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2015 3:59 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,307	112	2,941	1.00
2.00 HMO and other (see instructions)			368	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	1,307	112	2,941	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
25.10 CMHC - CORF	0.00					25.10
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: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part II Date/Time Prepared: 5/26/2015 3:59 pm			
	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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	19,935,756	0	19,935,756	733,956.87	27.16	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		495,698	0	495,698	18,967.26	26.13	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		408,129	0	408,129	12,938.57	31.54	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		95,677	0	95,677	601.71	159.01	13.00
14.00	Home office salaries & wage-related costs		6,979,684	0	6,979,684	174,612.31	39.97	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		5,534,611	0	5,534,611			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		141,331	0	141,331			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	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	2,640,420	0	2,640,420	75,097.77	35.16	27.00
28.00	Administrative & General under contract (see inst.)		260,253	0	260,253	3,586.49	72.56	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,135,486	0	1,135,486	48,935.87	23.20	30.00
31.00	Laundry & Linen Service	8.00	29,985	0	29,985	3,360.43	8.92	31.00
32.00	Housekeeping	9.00	893,726	0	893,726	69,114.52	12.93	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	409,522	-288,365	121,157	9,499.48	12.75	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	288,365	288,365	22,609.66	12.75	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	60,787	0	60,787	2,474.00	24.57	38.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150057

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

Worksheet S-3
Part II
Date/Time Prepared:
5/26/2015 3:59 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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		
39.00	Central Services and Supply	14.00	71,978	0	71,978	4,884.36	14.74	39.00
40.00	Pharmacy	15.00	752,305	0	752,305	19,627.59	38.33	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150057

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

Worksheet S-3
Part III
Date/Time Prepared:
5/26/2015 3:59 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Pai d Hours Related to Sal ari es i n 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)	20,196,009	0	20,196,009	737,543.36	27.38	1.00
2.00	Excluded area salaries (see instructions)	495,698	0	495,698	18,967.26	26.13	2.00
3.00	Subtotal salaries (line 1 minus line 2)	19,700,311	0	19,700,311	718,576.10	27.42	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,483,490	0	7,483,490	188,152.59	39.77	4.00
5.00	Subtotal wage-related costs (see inst.)	5,534,611	0	5,534,611	0.00	28.09	5.00
6.00	Total (sum of lines 3 thru 5)	32,718,412	0	32,718,412	906,728.69	36.08	6.00
7.00	Total overhead cost (see instructions)	6,254,462	0	6,254,462	259,190.17	24.13	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/26/2015 3:59 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		-5,216	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		1,265,473	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		2,502,264	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		145,426	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	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)		68,919	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		192,701	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		1,480,251	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		26,124	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		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		5,675,942	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Prepared: 5/26/2015 3:59 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	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/26/2015 3:59 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.263079	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		8,179,094	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		32,824,725	6.00	
7.00	Medicaid cost (line 1 times line 6)		8,635,496	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		456,402	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		456,402	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	19,486,941	0	19,486,941	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,126,605	0	5,126,605	21.00
22.00	Partial payment by patients approved for charity care	214,356	0	214,356	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,912,249	0	4,912,249	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,055,917	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		162,287	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		3,893,630	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,024,332	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,936,581	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,392,983	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150057

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

Worksheet A
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	0	7,331,613	7,331,613	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		5,187,092	-2,835,519	2,351,573	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,754,448	4,754,448	4.00
5.01	00570	ADMINISTRATIVE	706,985	186,192	-175,678	717,499	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.02
5.03	00590	OTHER ADMIN & GENERAL	1,933,435	15,420,102	-419,027	16,934,510	5.03
7.00	00700	OPERATION OF PLANT	1,135,486	1,951,808	-271,362	2,815,932	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,985	174,340	-8,004	196,321	8.00
9.00	00900	HOUSEKEEPING	893,726	408,745	-219,636	1,082,835	9.00
10.00	01000	DIETARY	409,522	322,869	-565,196	167,195	10.00
11.00	01100	CAFETERIA	0	0	453,460	453,460	11.00
13.00	01300	NURSING ADMINISTRATION	60,787	15,844	-14,456	62,175	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,978	37,646	-34,255	75,369	14.00
15.00	01500	PHARMACY	752,305	2,623,520	-2,474,032	901,793	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,962,802	2,404,879	-2,348,593	4,019,088	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,083,356	295,790	-287,253	1,091,893	34.00
43.00	04300	NURSERY	0	0	377,645	377,645	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,760,855	20,653,329	-15,245,182	7,169,002	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	231	85	854,088	854,404	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,277,994	694,162	-424,167	1,547,989	54.00
54.01	05401	ULTRA SOUND	202,022	53,924	-51,856	204,090	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	325,183	2,304,484	-79,439	2,550,228	55.00
60.00	06000	LABORATORY	0	2,420,324	-95,284	2,325,040	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	13,325	1,662,225	-1,350,257	325,293	64.00
65.00	06500	RESPIRATORY THERAPY	762,182	348,283	-388,070	722,395	65.00
66.00	06600	PHYSICAL THERAPY	1,187,549	329,945	-305,430	1,212,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,856	47,212	-42,153	137,915	67.00
68.00	06800	SPEECH PATHOLOGY	2,814	743	-743	2,814	68.00
69.00	06900	ELECTROCARDIOLOGY	63,694	316,643	-68,572	311,765	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	108,263	52,619	-47,292	113,590	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,238,229	4,238,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	11,569,429	11,569,429	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,322,489	3,322,489	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	386,836	133,597	-135,154	385,279	90.00
90.01	09001	WOUND CARE INSTITUTE	23,311	7,163	-6,920	23,554	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	21,570	5,240	-5,240	21,570	90.02
90.03	09003	BARITRIC MEDICINE	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,131,006	825,712	-658,252	2,298,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		4,225,474	-4,225,474	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,440,058	63,109,991	118,905	82,668,954	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,182	87,529	-9,159	116,552	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	101,859	111,347	-24,564	188,642	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	79,961	80,831	-18,411	142,381	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	275,558	505,067	-66,742	713,883	194.01
194.02	07952	JV MV ENDOSCOPY	0	3,445,700	0	3,445,700	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	194.03
194.04	07954	OTHER NRCC	138	29	-29	138	194.04
200.00		TOTAL (SUM OF LINES 118-199)	19,935,756	67,340,494	0	87,276,250	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150057

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

Worksheet A
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-3,426,457	3,905,156	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,351,573	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	224,661	4,979,109	4.00
5.01	00570	ADMINISTRATIVE	458,582	1,176,081	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,425,931	1,425,931	5.02
5.03	00590	OTHER ADMIN & GENERAL	11,592,793	28,527,303	5.03
7.00	00700	OPERATION OF PLANT	-3,600	2,812,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-14,501	181,820	8.00
9.00	00900	HOUSEKEEPING	-21,000	1,061,835	9.00
10.00	01000	DIETARY	-286,060	-118,865	10.00
11.00	01100	CAFETERIA	0	453,460	11.00
13.00	01300	NURSING ADMINISTRATION	0	62,175	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	75,369	14.00
15.00	01500	PHARMACY	-106,593	795,200	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	267,219	267,219	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	32,433	32,433	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	29,971	29,971	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,038	4,016,050	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	1,091,893	34.00
43.00	04300	NURSERY	0	377,645	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,302,783	5,866,219	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	854,404	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-23,931	1,524,058	54.00
54.01	05401	ULTRA SOUND	0	204,090	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-716,154	1,834,074	55.00
60.00	06000	LABORATORY	-1,781,946	543,094	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	-4,073	321,220	64.00
65.00	06500	RESPIRATORY THERAPY	-11,663	710,732	65.00
66.00	06600	PHYSICAL THERAPY	-9,501	1,202,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	137,915	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,814	68.00
69.00	06900	ELECTROCARDIOLOGY	0	311,765	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	113,590	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,238,229	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	11,569,429	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,322,489	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	385,279	90.00
90.01	09001	WOUND CARE INSTITUTE	0	23,554	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	21,570	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	90.04
91.00	09100	EMERGENCY	0	2,298,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,320,290	88,989,244	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	116,552	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	188,642	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	1,009,065	1,151,446	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	713,883	194.01
194.02	07952	JV MV ENDOSCOPY	0	3,445,700	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	224,457	224,457	194.03
194.04	07954	OTHER NRCC	0	138	194.04
200.00		TOTAL (SUM OF LINES 118-199)	7,553,812	94,830,062	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,238,229	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	11,569,429	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
TOTALS			0	15,807,658	
B - DRUG					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,322,489	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
TOTALS			0	3,322,489	
C - EQUIPMENT LEASE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	192,196	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
TOTALS			0	192,196	
D - DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	3,106,139	1.00
2.00		0.00	0	0	2.00
TOTALS			0	3,106,139	
E - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,225,474	1.00
TOTALS			0	4,225,474	
F - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,754,448	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
	TOTALS		0	4,754,448		
G - CAFETERIA						
1.00	CAFETERIA	11.00	288,365	165,095		1.00
	TOTALS		288,365	165,095		
H - NURSERY						
1.00	NURSERY	43.00	374,745	2,900		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	847,599	6,558		2.00
	TOTALS		1,222,344	9,458		
500.00	Grand Total: Increases		1,510,709	31,582,957		500.00

RECLASSIFICATIONS

Provider CCN: 150057

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

Worksheet A-6
Date/Time Prepared:
5/26/2015 3:59 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - MEDICAL SUPPLIES							
1.00	ADMINISTRATIVE	5.01	0	6,156	0		1.00
2.00	OTHER ADMIN & GENERAL	5.03	0	1,921	0		2.00
3.00	OPERATION OF PLANT	7.00	0	147	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	708	0		4.00
5.00	HOUSEKEEPING	9.00	0	3,793	0		5.00
6.00	DIETARY	10.00	0	4,472	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	562	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,843	0		8.00
9.00	PHARMACY	15.00	0	161,052	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	158,944	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	28,099	0		11.00
12.00	OPERATING ROOM	50.00	0	14,801,611	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	116,400	0		14.00
15.00	ULTRASOUND	54.01	0	3,455	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	836	0		16.00
17.00	LABORATORY	60.00	0	16,860	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	63,688	0		18.00
19.00	RESPIRATORY THERAPY	65.00	0	139,496	0		19.00
20.00	PHYSICAL THERAPY	66.00	0	17,645	0		20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	10,110	0		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	50,004	0		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	20,372	0		23.00
24.00	CLINIC	90.00	0	41,087	0		24.00
25.00	WOUND CARE INSTITUTE	90.01	0	1,261	0		25.00
26.00	EMERGENCY	91.00	0	142,125	0		26.00
TOTALS			0	15,807,658			
B - DRUG							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	244	0		1.00
2.00	PHARMACY	15.00	0	1,960,999	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	247	0		3.00
4.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	14	0		4.00
5.00	OPERATING ROOM	50.00	0	11,490	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	212	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	110	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	1,347,009	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	351	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1,288	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	92	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	295	0		12.00
13.00	EMERGENCY	91.00	0	138	0		13.00
TOTALS			0	3,322,489			
C - EQUIPMENT LEASE							
1.00	DIETARY	10.00	0	9,742	10		1.00
2.00	PHARMACY	15.00	0	171,458	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	127	0		3.00
4.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	109	0		4.00
5.00	OPERATING ROOM	50.00	0	9,963	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	90	0		6.00
7.00	ELECTROENCEPHALOGRAPHY	70.00	0	707	0		7.00
TOTALS			0	192,196			
D - DEPRECIATION							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,027,715	9		1.00
2.00	LABORATORY	60.00	0	78,424	0		2.00
TOTALS			0	3,106,139			
E - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	4,225,474	11		1.00
TOTALS			0	4,225,474			
F - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE	5.01	0	169,522	0		1.00
2.00	OTHER ADMIN & GENERAL	5.03	0	417,106	0		2.00
3.00	OPERATION OF PLANT	7.00	0	271,215	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	7,296	0		4.00
5.00	HOUSEKEEPING	9.00	0	215,843	0		5.00
6.00	DIETARY	10.00	0	97,522	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	13,894	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	17,168	0		8.00
9.00	PHARMACY	15.00	0	180,523	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	957,473	0		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	259,031	0		11.00
12.00	OPERATING ROOM	50.00	0	422,118	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	58	0		13.00

Decreases								
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.			
6.00	7.00	8.00	9.00	10.00				
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	307,555	0		14.00	
15.00	ULTRASOUND	54.01	0	48,401	0		15.00	
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	78,493	0		16.00	
17.00	INTRAVENOUS THERAPY	64.00	0	3,248	0		17.00	
18.00	RESPIRATORY THERAPY	65.00	0	184,445	0		18.00	
19.00	PHYSICAL THERAPY	66.00	0	286,497	0		19.00	
20.00	OCCUPATIONAL THERAPY	67.00	0	31,951	0		20.00	
21.00	SPEECH PATHOLOGY	68.00	0	743	0		21.00	
22.00	ELECTROCARDIOLOGY	69.00	0	18,273	0		22.00	
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	26,213	0		23.00	
24.00	CLINIC	90.00	0	94,067	0		24.00	
25.00	WOUND CARE INSTITUTE	90.01	0	5,659	0		25.00	
26.00	OP NUTRITIONAL COUNSELING	90.02	0	5,240	0		26.00	
27.00	EMERGENCY	91.00	0	515,989	0		27.00	
28.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	9,159	0		28.00	
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	24,564	0		29.00	
30.00	COMMUNITY RELATIONS & MARKETING	194.00	0	18,411	0		30.00	
31.00	PLAINFIELD RADIOLOGY & PHYSICAL THER	194.01	0	66,742	0		31.00	
32.00	OTHER NRCC	194.04	0	29	0		32.00	
	TOTALS		0	4,754,448				
G - CAFETERIA								
1.00	DIETARY	10.00	288,365	165,095	0		1.00	
	TOTALS		288,365	165,095				
H - NURSERY								
1.00	ADULTS & PEDIATRICS	30.00	1,222,344	9,458	0		1.00	
2.00		0.00	0	0	0		2.00	
	TOTALS		1,222,344	9,458				
500.00	Grand Total: Decreases		1,510,709	31,582,957			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150057

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

Worksheet A-7
Part I
Date/Time Prepared:
5/26/2015 3:59 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	0	0	0	0	0	1.00
2.00	Land Improvements	1,434,719	39,092	0	39,092	0	2.00
3.00	Buildings and Fixtures	55,967,448	1,407,597	0	1,407,597	0	3.00
4.00	Building Improvements	1,323,774	0	0	0	261,190	4.00
5.00	Fixed Equipment	25,007,540	1,694,905	0	1,694,905	0	5.00
6.00	Movable Equipment	22,652,825	0	0	0	1,346,941	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	106,386,306	3,141,594	0	3,141,594	1,608,131	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	106,386,306	3,141,594	0	3,141,594	1,608,131	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	1,473,811	712,104				2.00
3.00	Buildings and Fixtures	57,375,045	1,024,594				3.00
4.00	Building Improvements	1,062,584	431,819				4.00
5.00	Fixed Equipment	26,702,445	101,662				5.00
6.00	Movable Equipment	21,305,884	11,029,125				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	107,919,769	13,299,304				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	107,919,769	13,299,304				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150057

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

Worksheet A-7
Part II
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5,187,092	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,187,092	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	5,187,092		2.00		
3.00	Total (sum of lines 1-2)	0	5,187,092		3.00		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150057

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

Worksheet A-7
Part III
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	86,613,885	0	86,613,885	0.802577	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	21,305,884	0	21,305,884	0.197423	0	2.00
3.00	Total (sum of lines 1-2)	107,919,769	0	107,919,769	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,106,139	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,159,377	192,196	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,265,516	192,196	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	799,017	0	0	0	3,905,156	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,351,573	2.00
3.00	Total (sum of lines 1-2)	799,017	0	0	0	6,256,729	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150057

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

Worksheet A-8

Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-110	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	B	-113,547	OTHER ADMIN & GENERAL	5.03	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	-3,131,488			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	12,693,041			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-236,652	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-8,162	DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 150057

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

Worksheet A-8
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00
33.00 MISC REVENUE - A&G	B	-217,468	OTHER ADMIN & GENERAL	5.03		0 33.00
34.00 MISC REVENUE - ENGINEERING	B	-3,600	OPERATION OF PLANT	7.00		0 34.00
35.00 MISC REVENUE - LINEN	B	-14,501	LAUNDRY & LINEN SERVICE	8.00		0 35.00
36.00 MISC REVENUE - ENVIRONMENTAL SVCS	B	-21,000	HOUSEKEEPING	9.00		0 36.00
37.00 MISC REVENUE - DIETARY	B	-41,246	DIETARY	10.00		0 37.00
38.00 MISC REVENUE - PHARMACY	B	-139,782	PHARMACY	15.00		0 38.00
39.00 MISC REVENUE - A&P	B	-3,038	ADULTS & PEDIATRICS	30.00		0 39.00
40.00 MISC REVENUE - OPERATING	B	-58,812	OPERATING ROOM	50.00		0 40.00
41.00 MISC REVENUE - RADIOLOGY	B	-5,232	RADIOLOGY-DIAGNOSTIC	54.00		0 41.00
42.00 MISC REVENUE - RADIATION THERAPY	B	-716,154	RADIOLOGY-THERAPEUTIC	55.00		0 42.00
43.00 MISC REVENUE - IV THERAPY	B	-4,073	INTRAVENOUS THERAPY	64.00		0 43.00
44.00 MISC REVENUE - RESPIRATORY CARE	B	-748	RESPIRATORY THERAPY	65.00		0 44.00
45.00 MISC REVENUE - PHYSICAL THERAPY	B	-9,501	PHYSICAL THERAPY	66.00		0 45.00
46.00 ADMIN - DONATIONS EXPENSE	A	-660	OTHER ADMIN & GENERAL	5.03		0 46.00
47.00 NONALLOWABLE INTEREST	A	-413,455	NEW CAP REL COSTS-BLDG & FIXT	1.00		11 47.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		7,553,812				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: 150057

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

Worksheet A-8-1

Date/Time Prepared: 5/26/2015 3:59 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	224,661	0 1.00
2.00	5.01	ADMINISTRATIVE	SHARED SERVICE ALLOCATION	458,582	0 2.00
3.00	5.02	CASHIERING/ACCOUNTS RECEIVABLE	SHARED SERVICE ALLOCATION	1,425,931	0 3.00
4.00	5.03	OTHER ADMIN & GENERAL	SHARED SERVICE ALLOCATION	6,102,685	0 4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	267,219	0 4.01
4.02	194.00	COMMUNITY RELATIONS & MARKET	SHARED SERVICE ALLOCATION	1,009,065	0 4.02
4.03	194.03	SOUTHWEST CENTER FOR WOMENS	SHARED SERVICE ALLOCATION	224,457	0 4.03
4.04	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	912,617	0 4.04
4.06	1.00	NEW CAP REL COSTS-BLDG & FIX	FRANCISCAN HOME OFFICE	665,561	3,678,453 4.06
4.07	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	4,941,102	0 4.07
4.08	15.00	PHARMACY	FRANCISCAN HOME OFFICE	128,201	83,530 4.08
4.09	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	32,433	0 4.09
4.10	22.00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	29,971	0 4.10
4.11	60.00	LABORATORY	APHL LAB	2,188,102	2,155,563 4.11
5.00	0			18,610,587	5,917,546 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	A	HOME OFFICE	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.

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

Provider CCN: 150057

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

Worksheet A-8-1

Date/Time Prepared:
5/26/2015 3:59 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	224,661	0		1.00
2.00	458,582	0		2.00
3.00	1,425,931	0		3.00
4.00	6,102,685	0		4.00
4.01	267,219	0		4.01
4.02	1,009,065	0		4.02
4.03	224,457	0		4.03
4.04	912,617	0		4.04
4.06	-3,012,892	11		4.06
4.07	4,941,102	0		4.07
4.08	44,671	0		4.08
4.09	32,433	0		4.09
4.10	29,971	0		4.10
4.11	32,539	0		4.11
5.00	12,693,041			5.00

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

Related Organization(s) and/or Home Office	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150057

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

Worksheet A-8-2

Date/Time Prepared:
5/26/2015 3:59 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	5.03 OTHER ADMIN & GENERAL	52,608	12,108	40,500	138,700	310	1.00
2.00	15.00 PHARMACY	17,417	4,035	13,382	138,700	89	2.00
3.00	50.00 OPERATING ROOM	1,244,771	1,243,451	1,320	138,700	12	3.00
4.00	54.00 RADIOLOGY-DIAGNOSTIC	22,500	1,875	20,625	138,700	57	4.00
5.00	60.00 LABORATORY	1,814,485	1,814,485	0	0	0	5.00
6.00	65.00 RESPIRATORY THERAPY	19,850	0	19,850	138,700	134	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		3,171,631	3,075,954	95,677		602	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	5.03 OTHER ADMIN & GENERAL	20,672	1,034	0	0	0	1.00
2.00	15.00 PHARMACY	5,935	297	0	0	0	2.00
3.00	50.00 OPERATING ROOM	800	40	0	0	0	3.00
4.00	54.00 RADIOLOGY-DIAGNOSTIC	3,801	190	0	0	0	4.00
5.00	60.00 LABORATORY	0	0	0	0	0	5.00
6.00	65.00 RESPIRATORY THERAPY	8,935	447	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		40,143	2,008	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	5.03 OTHER ADMIN & GENERAL	0	20,672	19,828	31,936	1.00
2.00	15.00 PHARMACY	0	5,935	7,447	11,482	2.00
3.00	50.00 OPERATING ROOM	0	800	520	1,243,971	3.00
4.00	54.00 RADIOLOGY-DIAGNOSTIC	0	3,801	16,824	18,699	4.00
5.00	60.00 LABORATORY	0	0	0	1,814,485	5.00
6.00	65.00 RESPIRATORY THERAPY	0	8,935	10,915	10,915	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	40,143	55,534	3,131,488	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	3,905,156	3,905,156			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	2,351,573		2,351,573		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,979,109	13,595	8,186	5,000,890	4.00
5.01 00570	ADMITTING	1,176,081	45,864	27,618	177,347	1,426,910 5.01
5.02 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,425,931	0	0	0	0 5.02
5.03 00590	OTHER ADMIN & GENERAL	28,527,303	106,093	63,886	485,002	0 5.03
7.00 00700	OPERATION OF PLANT	2,812,332	131,891	79,421	284,837	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	181,820	6,303	3,795	7,522	0 8.00
9.00 00900	HOUSEKEEPING	1,061,835	26,502	15,959	224,191	0 9.00
10.00 01000	DIETARY	-118,865	99,874	60,141	30,392	0 10.00
11.00 01100	CAFETERIA	453,460	0	0	72,336	0 11.00
13.00 01300	NURSING ADMINISTRATION	62,175	0	0	15,248	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	75,369	0	0	18,056	0 14.00
15.00 01500	PHARMACY	795,200	0	0	188,716	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	267,219	32,788	19,744	0	0 16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	32,433	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	29,971	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,016,050	927,764	558,675	687,448	146,468 30.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	1,091,893	90,772	54,660	271,760	27,460 34.00
43.00 04300	NURSERY	377,645	0	0	94,005	13,723 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,866,219	554,151	333,694	441,710	232,387 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	854,404	0	0	212,678	30,704 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,524,058	187,226	112,742	320,585	38,399 54.00
54.01 05401	ULTRA SOUND	204,090	5,699	3,432	50,677	3,283 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,834,074	143,156	86,204	81,572	694 55.00
60.00 06000	LABORATORY	543,094	68,125	41,023	0	71,351 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
64.00 06400	INTRAVENOUS THERAPY	321,220	0	0	3,343	3,455 64.00
65.00 06500	RESPIRATORY THERAPY	710,732	22,714	13,678	191,193	38,525 65.00
66.00 06600	PHYSICAL THERAPY	1,202,563	87,771	52,853	297,897	32,136 66.00
67.00 06700	OCCUPATIONAL THERAPY	137,915	0	0	33,327	4,472 67.00
68.00 06800	SPEECH PATHOLOGY	2,814	0	0	706	1,517 68.00
69.00 06900	ELECTROCARDIOLOGY	311,765	45,076	27,143	15,978	5,810 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	113,590	60,883	36,662	27,158	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,238,229	20,518	12,355	0	210,431 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	11,569,429	0	0	0	365,870 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,322,489	43,114	25,962	0	136,564 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	385,279	0	0	97,038	58 90.00
90.01 09001	WOUND CARE INSTITUTE	23,554	0	0	5,848	43 90.01
90.02 09002	OP NUTRITIONAL COUNSELING	21,570	0	0	5,411	0 90.02
90.03 09003	BARITRIC MEDICINE	0	0	0	0	0 90.03
90.04 04950	MARKETING & PLANNING	0	0	0	0	0 90.04
91.00 09100	EMERGENCY	2,298,466	246,315	148,324	534,563	63,560 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	88,989,244	2,966,194	1,786,157	4,876,544	1,426,910 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	116,552	0	0	9,578	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	188,642	855,365	515,076	25,551	0 192.00
194.00 07950	COMMUNITY RELATIONS & MARKETING	1,151,446	0	0	20,058	0 194.00
194.01 07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	713,883	0	0	69,124	0 194.01
194.02 07952	JV MV ENDOSCOPY	3,445,700	83,597	50,340	0	0 194.02
194.03 07953	SOUTHWEST CENTER FOR WOMENS HEALTH	224,457	0	0	0	0 194.03
194.04 07954	OTHER NRCC	138	0	0	35	0 194.04
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	94,830,062	3,905,156	2,351,573	5,000,890	1,426,910 202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared: 5/26/2015 3:59 pm		
Cost Center	Description	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.02	5A.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,425,931				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	29,182,284	29,182,284		5.03
7.00	00700	OPERATION OF PLANT	0	3,308,481	1,470,712	4,779,193	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	199,440	88,657	8,350	296,447
8.00	00800	LAUNDRY & LINEN SERVICE	0	199,440	88,657	8,350	296,447
9.00	00900	HOUSEKEEPING	0	1,328,487	590,550	35,108	0
10.00	01000	DIETARY	0	71,542	31,802	132,304	0
11.00	01100	CAFETERIA	0	525,796	233,731	0	0
13.00	01300	NURSING ADMINISTRATION	0	77,423	34,417	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93,425	41,530	0	0
15.00	01500	PHARMACY	0	983,916	437,378	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	319,751	142,138	43,435	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	32,433	14,417	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	29,971	13,323	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	54,859	6,391,264	2,841,096	1,229,025	46,145
34.00	03400	SURGICAL INTENSIVE CARE UNIT	9,678	1,546,223	687,339	120,246	81,276
43.00	04300	NURSERY	4,837	490,210	217,912	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	121,875	7,550,036	3,356,202	734,092	53,010
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,936	1,108,722	492,858	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,685	2,400,695	1,067,176	248,021	27,553
54.01	05401	ULTRA SOUND	20,428	287,609	127,850	7,550	0
55.00	05500	RADIOLOGY-THERAPEUTIC	40,337	2,186,037	971,755	189,641	3,768
60.00	06000	LABORATORY	126,332	849,925	377,815	90,246	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	10,264	338,282	150,376	0	0
65.00	06500	RESPIRATORY THERAPY	19,628	996,470	442,959	30,089	0
66.00	06600	PHYSICAL THERAPY	40,477	1,713,697	761,786	116,272	5,750
67.00	06700	OCCUPATIONAL THERAPY	4,363	180,077	80,049	0	2,453
68.00	06800	SPEECH PATHOLOGY	546	5,583	2,482	0	0
69.00	06900	ELECTROCARDIOLOGY	32,811	438,583	194,962	59,712	0
70.00	07000	ELECTROENCEPHALOGRAPHY	12,659	250,952	111,555	80,653	1,790
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,747	4,585,280	2,038,285	27,180	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	141,276	12,076,575	5,368,388	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	158,927	3,687,056	1,639,000	57,114	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	14,570	496,945	220,906	0	1,936
90.01	09001	WOUND CARE INSTITUTE	891	30,336	13,485	0	42
90.02	09002	OP NUTRITIONAL COUNSELING	304	27,285	12,129	0	0
90.03	09003	BARITRIC MEDICINE	0	0	0	0	0
90.04	04950	MARKETING & PLANNING	0	0	0	0	0
91.00	09100	EMERGENCY	278,501	3,569,729	1,586,844	326,298	57,420
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,425,931	87,360,520	25,861,864	3,535,336	281,143
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	126,130	56,068	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,584,634	704,414	1,133,115	221
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	1,171,504	520,766	0	0
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	783,007	348,069	0	0
194.02	07952	JV MV ENDOSCOPY	0	3,579,637	1,591,249	110,742	15,083
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	224,457	99,777	0	0
194.04	07954	OTHER NRCC	0	173	77	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,425,931	94,830,062	29,182,284	4,779,193	296,447

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part I Date/Time Prepared: 5/26/2015 3:59 pm	
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00590	OTHER ADMIN & GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING	1,954,145				9.00
10.00	01000	DIETARY	54,594	290,242			10.00
11.00	01100	CAFETERIA	0	0	759,527		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	3,718	115,558	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	7,341	0	14.00
15.00	01500	PHARMACY	0	0	29,501	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,923	0	0	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	507,143	240,151	92,869	24,009	192
34.00	03400	SURGICAL INTENSIVE CARE UNIT	49,618	30,198	48,589	12,562	30
43.00	04300	NURSERY	0	19,893	31,467	8,135	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	302,914	0	97,402	25,181	661
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	71,188	18,404	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,343	0	76,895	0	151
54.01	05401	ULTRA SOUND	3,115	0	7,919	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	78,253	0	17,719	0	388
60.00	06000	LABORATORY	37,239	0	0	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	479	0	45
65.00	06500	RESPIRATORY THERAPY	12,416	0	38,453	0	13
66.00	06600	PHYSICAL THERAPY	47,978	0	62,040	0	76
67.00	06700	OCCUPATIONAL THERAPY	0	0	9,030	0	31
68.00	06800	SPEECH PATHOLOGY	0	0	116	0	0
69.00	06900	ELECTROCARDIOLOGY	24,640	0	2,270	0	444
70.00	07000	ELECTROENCEPHALOGRAPHY	33,280	0	5,190	0	21
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,216	0	0	0	37,279
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	101,760
73.00	07300	DRUGS CHARGED TO PATIENTS	23,568	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	21,092	0	24
90.01	09001	WOUND CARE INSTITUTE	0	0	1,178	0	0
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	1,094	0	0
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	0
90.04	04950	MARKETING & PLANNING	0	0	0	0	0
91.00	09100	EMERGENCY	134,643	0	105,468	27,267	208
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,440,883	290,242	731,018	115,558	141,419
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,324	0	678
192.00	19200	PHYSICIANS' PRIVATE OFFICES	467,566	0	6,878	0	125
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	3,666	0	2
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	12,627	0	72
194.02	07952	JV MV ENDOSCOPY	45,696	0	0	0	0
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0
194.04	07954	OTHER NRCC	0	0	14	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,954,145	290,242	759,527	115,558	142,296

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared: 5/26/2015 3:59 pm
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			15.00	16.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00570 ADMITTING						5.01
5.02 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03 00590 OTHER ADMIN & GENERAL						5.03
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	1,450,891					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	523,247				16.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	46,850			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	43,294		22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	20,132	46,850	43,294	11,482,170	30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	3,552	0	0	2,579,633	34.00
43.00 04300 NURSERY	0	1,775	0	0	769,392	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	44,726	0	0	12,164,224	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	4,013	0	0	1,695,185	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	79,886	0	0	4,002,720	54.00
54.01 05401 ULTRA SOUND	0	7,497	0	0	441,540	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	14,803	0	0	3,462,364	55.00
60.00 06000 LABORATORY	0	46,361	0	0	1,401,586	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	3,767	0	0	492,949	64.00
65.00 06500 RESPIRATORY THERAPY	0	7,203	0	0	1,527,603	65.00
66.00 06600 PHYSICAL THERAPY	0	14,854	0	0	2,722,453	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,601	0	0	273,241	67.00
68.00 06800 SPEECH PATHOLOGY	0	200	0	0	8,381	68.00
69.00 06900 ELECTROCARDIOLOGY	0	12,041	0	0	732,652	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	4,646	0	0	488,087	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,073	0	0	6,737,313	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	51,846	0	0	17,598,569	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,450,891	58,323	0	0	6,915,952	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	5,347	0	0	746,250	90.00
90.01 09001 WOUND CARE INSTITUTE	0	327	0	0	45,368	90.01
90.02 09002 OP NUTRITIONAL COUNSELING	0	112	0	0	40,620	90.02
90.03 09003 BARIATRIC MEDICINE	0	0	0	0	0	90.03
90.04 04950 MARKETING & PLANNING	0	0	0	0	0	90.04
91.00 09100 EMERGENCY	0	102,162	0	0	5,910,039	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00						118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	188,200	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,896,953	192.00
194.00 07950 COMMUNITY RELATIONS & MARKETING	0	0	0	0	1,695,938	194.00
194.01 07951 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	0	0	1,143,775	194.01
194.02 07952 JV MV ENDOSCOPY	0	0	0	0	5,342,407	194.02
194.03 07953 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	324,234	194.03
194.04 07954 OTHER NRCC	0	0	0	0	264	194.04
200.00						200.00
201.00						201.00
202.00						202.00
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,450,891	523,247	46,850	43,294	94,830,062	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150057

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

Worksheet B
Part I
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.02
5.03	00590	OTHER ADMIN & GENERAL		5.03
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-90,144	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	34.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	ULTRA SOUND	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	90.02
90.03	09003	BIARIATRIC MEDICINE	0	90.03
90.04	04950	MARKETING & PLANNING	0	90.04
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-90,144	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	194.03
194.04	07954	OTHER NRCC	0	194.04
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	-90,144	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/26/2015 3:59 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,595	8,186	21,781	21,781 4.00
5.01 00570	ADMINISTRATIVE	0	45,864	27,618	73,482	773 5.01
5.02 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0 5.02
5.03 00590	OTHER ADMIN & GENERAL	0	106,093	63,886	169,979	2,113 5.03
7.00 00700	OPERATION OF PLANT	912,617	131,891	79,421	1,123,929	1,241 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,303	3,795	10,098	33 8.00
9.00 00900	HOUSEKEEPING	0	26,502	15,959	42,461	977 9.00
10.00 01000	DIETARY	0	99,874	60,141	160,015	132 10.00
11.00 01100	CAFETERIA	0	0	0	0	315 11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	66 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	79 14.00
15.00 01500	PHARMACY	0	0	0	0	822 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	32,788	19,744	52,532	0 16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	927,764	558,675	1,486,439	2,987 30.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	90,772	54,660	145,432	1,184 34.00
43.00 04300	NURSERY	0	0	0	0	410 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	554,151	333,694	887,845	1,925 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	927 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	187,226	112,742	299,968	1,397 54.00
54.01 05401	ULTRA SOUND	0	5,699	3,432	9,131	221 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	143,156	86,204	229,360	355 55.00
60.00 06000	LABORATORY	0	68,125	41,023	109,148	0 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	15 64.00
65.00 06500	RESPIRATORY THERAPY	0	22,714	13,678	36,392	833 65.00
66.00 06600	PHYSICAL THERAPY	0	87,771	52,853	140,624	1,298 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	145 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	3 68.00
69.00 06900	ELECTROCARDIOLOGY	0	45,076	27,143	72,219	70 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	60,883	36,662	97,545	118 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,518	12,355	32,873	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	43,114	25,962	69,076	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	423 90.00
90.01 09001	WOUND CARE INSTITUTE	0	0	0	0	25 90.01
90.02 09002	OP NUTRITIONAL COUNSELING	0	0	0	0	24 90.02
90.03 09003	BARITRIC MEDICINE	0	0	0	0	0 90.03
90.04 04950	MARKETING & PLANNING	0	0	0	0	0 90.04
91.00 09100	EMERGENCY	0	246,315	148,324	394,639	2,329 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	912,617	2,966,194	1,786,157	5,664,968	21,240 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	42 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	855,365	515,076	1,370,441	111 192.00
194.00 07950	COMMUNITY RELATIONS & MARKETING	0	0	0	0	87 194.00
194.01 07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	0	0	301 194.01
194.02 07952	JVMV ENDOSCOPY	0	83,597	50,340	133,937	0 194.02
194.03 07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0 194.03
194.04 07954	OTHER NRCC	0	0	0	0	0 194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	912,617	3,905,156	2,351,573	7,169,346	21,781 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/26/2015 3:59 pm	
Cost Center Description			ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMINISTRATIVE	74,255					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0				5.02
5.03	00590	OTHER ADMIN & GENERAL	0	0	172,092			5.03
7.00	00700	OPERATION OF PLANT	0	0	8,672	1,133,842		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	523	1,981	12,635	8.00
9.00	00900	HOUSEKEEPING	0	0	3,482	8,329	0	9.00
10.00	01000	DIETARY	0	0	188	31,389	0	10.00
11.00	01100	CAFETERIA	0	0	1,378	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	203	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	245	0	0	14.00
15.00	01500	PHARMACY	0	0	2,579	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	838	10,305	0	16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	85	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	79	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,618	0	16,752	291,580	1,967	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,428	0	4,053	28,528	3,464	34.00
43.00	04300	NURSERY	714	0	1,285	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,087	0	19,789	174,160	2,259	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,597	0	2,906	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,997	0	6,292	58,842	1,174	54.00
54.01	05401	ULTRA SOUND	171	0	754	1,791	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	36	0	5,730	44,991	161	55.00
60.00	06000	LABORATORY	3,711	0	2,228	21,410	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	180	0	887	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,004	0	2,612	7,139	0	65.00
66.00	06600	PHYSICAL THERAPY	1,672	0	4,492	27,585	245	66.00
67.00	06700	OCCUPATIONAL THERAPY	233	0	472	0	105	67.00
68.00	06800	SPEECH PATHOLOGY	79	0	15	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	302	0	1,150	14,167	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	658	19,135	76	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,945	0	12,018	6,448	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,067	0	31,676	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,103	0	9,664	13,550	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3	0	1,302	0	83	90.00
90.01	09001	WOUND CARE INSTITUTE	2	0	80	0	2	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	72	0	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	3,306	0	9,356	77,413	2,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,255	0	152,515	838,743	11,983	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	331	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,153	268,826	9	192.00
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	0	3,071	0	0	194.00
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	2,052	0	0	194.01
194.02	07952	JV MV ENDOSCOPY	0	0	9,382	26,273	643	194.02
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	588	0	0	194.03
194.04	07954	OTHER NRCC	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	74,255	0	172,092	1,133,842	12,635	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/26/2015 3:59 pm			
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00570						5.01
5.02	00580						5.02
5.03	00590						5.03
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	55,249					9.00
10.00	01000	1,544	137,114				10.00
11.00	01100	0	0	1,693			11.00
13.00	01300	0	0	8	277		13.00
14.00	01400	0	0	16	0	340	14.00
15.00	01500	0	0	66	0	0	15.00
16.00	01600	507	0	0	0	0	16.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	14,338	113,450	207	58	0	30.00
34.00	03400	1,403	14,266	108	30	0	34.00
43.00	04300	0	9,398	70	19	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,564	0	217	60	2	50.00
52.00	05200	0	0	159	44	0	52.00
54.00	05400	2,894	0	171	0	0	54.00
54.01	05401	88	0	18	0	0	54.01
55.00	05500	2,212	0	39	0	1	55.00
60.00	06000	1,053	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	1	0	0	64.00
65.00	06500	351	0	86	0	0	65.00
66.00	06600	1,356	0	138	0	0	66.00
67.00	06700	0	0	20	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	697	0	5	0	1	69.00
70.00	07000	941	0	12	0	0	70.00
71.00	07100	317	0	0	0	89	71.00
72.00	07200	0	0	0	0	245	72.00
73.00	07300	666	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	47	0	0	90.00
90.01	09001	0	0	3	0	0	90.01
90.02	09002	0	0	2	0	0	90.02
90.03	09003	0	0	0	0	0	90.03
90.04	04950	0	0	0	0	0	90.04
91.00	09100	3,807	0	237	66	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		40,738	137,114	1,630	277	338	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	12	0	2	190.00
192.00	19200	13,219	0	15	0	0	192.00
194.00	07950	0	0	8	0	0	194.00
194.01	07951	0	0	28	0	0	194.01
194.02	07952	1,292	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	56,154	0	0	0	201.00
202.00		55,249	193,268	1,693	277	340	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/26/2015 3:59 pm
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			15.00	16.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00570	ADMITTING					5.01
5.02 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03 00590	OTHER ADMIN & GENERAL					5.03
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY	3,467				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	64,182			16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	85		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		79	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	2,474			1,937,870 30.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	437			200,333 34.00
43.00 04300	NURSERY	0	218			12,114 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	5,497			1,112,405 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	493			6,126 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	9,819			382,554 54.00
54.01 05401	ULTRA SOUND	0	921			13,095 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	1,819			284,704 55.00
60.00 06000	LABORATORY	0	5,698			143,248 60.00
60.01 06001	BLOOD LABORATORY	0	0			0 60.01
64.00 06400	INTRAVENOUS THERAPY	0	463			1,546 64.00
65.00 06500	RESPIRATORY THERAPY	0	885			50,302 65.00
66.00 06600	PHYSICAL THERAPY	0	1,826			179,236 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	197			1,172 67.00
68.00 06800	SPEECH PATHOLOGY	0	25			122 68.00
69.00 06900	ELECTROCARDIOLOGY	0	1,480			90,091 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	571			119,056 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,680			67,370 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	6,372			57,360 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3,467	7,169			110,695 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	657			2,515 90.00
90.01 09001	WOUND CARE INSTITUTE	0	40			152 90.01
90.02 09002	OP NUTRITIONAL COUNSELING	0	14			112 90.02
90.03 09003	BARIATRIC MEDICINE	0	0			0 90.03
90.04 04950	MARKETING & PLANNING	0	0			0 90.04
91.00 09100	EMERGENCY	0	12,427			506,027 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0			0 99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					387 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,467	64,182	0	0	5,278,205 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			387 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0			1,656,774 192.00
194.00 07950	COMMUNITY RELATIONS & MARKETING	0	0			3,166 194.00
194.01 07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0			2,381 194.01
194.02 07952	JV MV ENDOSCOPY	0	0			171,527 194.02
194.03 07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0			588 194.03
194.04 07954	OTHER NRCC	0	0			0 194.04
200.00	Cross Foot Adjustments			85	79	164 200.00
201.00	Negative Cost Centers	0	0	0	0	56,154 201.00
202.00	TOTAL (sum lines 118-201)	3,467	64,182	85	79	7,169,346 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/26/2015 3:59 pm
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.02
5.03	00590	OTHER ADMIN & GENERAL		5.03
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,937,870
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	200,333
43.00	04300	NURSERY	0	12,114
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,112,405
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,126
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	382,554
54.01	05401	ULTRA SOUND	0	13,095
55.00	05500	RADIOLOGY-THERAPEUTIC	0	284,704
60.00	06000	LABORATORY	0	143,248
60.01	06001	BLOOD LABORATORY	0	0
64.00	06400	INTRAVENOUS THERAPY	0	1,546
65.00	06500	RESPIRATORY THERAPY	0	50,302
66.00	06600	PHYSICAL THERAPY	0	179,236
67.00	06700	OCCUPATIONAL THERAPY	0	1,172
68.00	06800	SPEECH PATHOLOGY	0	122
69.00	06900	ELECTROCARDIOLOGY	0	90,091
70.00	07000	ELECTROENCEPHALOGRAPHY	0	119,056
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	67,370
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	57,360
73.00	07300	DRUGS CHARGED TO PATIENTS	0	110,695
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	2,515
90.01	09001	WOUND CARE INSTITUTE	0	152
90.02	09002	OP NUTRITIONAL COUNSELING	0	112
90.03	09003	BIARIATRIC MEDICINE	0	0
90.04	04950	MARKETING & PLANNING	0	0
91.00	09100	EMERGENCY	0	506,027
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,278,205
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	387
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,656,774
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	3,166
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	2,381
194.02	07952	JV MV ENDOSCOPY	0	171,527
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	588
194.04	07954	OTHER NRCC	0	0
200.00		Cross Foot Adjustments	0	164
201.00		Negative Cost Centers	0	56,154
202.00		TOTAL (sum lines 118-201)	0	7,169,346

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

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

Worksheet B-1
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	232,963				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		232,963			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	811	811	19,935,756		4.00
5.01 00570	ADMITTING	2,736	2,736	706,985	110,114,383	5.01
5.02 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	312,257,058	5.02
5.03 00590	OTHER ADMIN & GENERAL	6,329	6,329	1,933,435	0	5.03
7.00 00700	OPERATION OF PLANT	7,868	7,868	1,135,486	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	376	376	29,985	0	8.00
9.00 00900	HOUSEKEEPING	1,581	1,581	893,726	0	9.00
10.00 01000	DIETARY	5,958	5,958	121,157	0	10.00
11.00 01100	CAFETERIA	0	0	288,365	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	60,787	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	71,978	0	14.00
15.00 01500	PHARMACY	0	0	752,305	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,956	1,956	0	0	16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	55,346	55,346	2,740,458	11,303,289	12,012,076
34.00 03400	SURGICAL INTENSIVE CARE UNIT	5,415	5,415	1,083,356	2,119,173	2,119,173
43.00 04300	NURSERY	0	0	374,745	1,059,032	1,059,032
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	33,058	33,058	1,760,855	17,933,835	26,685,951
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	847,830	2,369,479	2,394,467
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,169	11,169	1,277,994	2,963,348	47,664,719
54.01 05401	ULTRA SOUND	340	340	202,022	253,339	4,472,859
55.00 05500	RADIOLOGY-THERAPEUTIC	8,540	8,540	325,183	53,554	8,832,169
60.00 06000	LABORATORY	4,064	4,064	0	5,506,366	27,661,858
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	13,325	266,616	2,247,331
65.00 06500	RESPIRATORY THERAPY	1,355	1,355	762,182	2,973,087	4,297,822
66.00 06600	PHYSICAL THERAPY	5,236	5,236	1,187,549	2,480,041	8,862,991
67.00 06700	OCCUPATIONAL THERAPY	0	0	132,856	345,148	955,260
68.00 06800	SPEECH PATHOLOGY	0	0	2,814	117,076	119,479
69.00 06900	ELECTROCARDIOLOGY	2,689	2,689	63,694	448,337	7,184,271
70.00 07000	ELECTROENCEPHALOGRAPHY	3,632	3,632	108,263	0	2,771,897
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,224	1,224	0	16,239,480	22,716,674
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	28,231,380	30,934,194
73.00 07300	DRUGS CHARGED TO PATIENTS	2,572	2,572	0	10,538,976	34,798,951
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	386,836	4,447	3,190,256
90.01 09001	WOUND CARE INSTITUTE	0	0	23,311	3,320	195,123
90.02 09002	OP NUTRITIONAL COUNSELING	0	0	21,570	0	66,577
90.03 09003	BARIATRIC MEDICINE	0	0	0	0	0
90.04 04950	MARKETING & PLANNING	0	0	0	0	0
91.00 09100	EMERGENCY	14,694	14,694	2,131,006	4,905,060	61,013,928
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	176,949	176,949	19,440,058	110,114,383	312,257,058
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	38,182	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	51,027	51,027	101,859	0	0
194.00 07950	COMMUNITY RELATIONS & MARKETING	0	0	79,961	0	0
194.01 07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	275,558	0	0
194.02 07952	JV MV ENDOSCOPY	4,987	4,987	0	0	0
194.03 07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0
194.04 07954	OTHER NRCC	0	0	138	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	3,905,156	2,351,573	5,000,890	1,426,910	1,425,931
203.00	Unit cost multiplier (Wkst. B, Part I)	16.762988	10.094191	0.250850	0.012958	0.004567
204.00	Cost to be allocated (per Wkst. B, Part II)			21,781	74,255	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

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

Worksheet B-1

Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001093	0.000674	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet B-1		Date/Time Prepared: 5/26/2015 3:59 pm	
Cost Center	Description	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.03	5.03	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03	00590	OTHER ADMIN & GENERAL	-29,182,284	65,647,778			5.03
7.00	00700	OPERATION OF PLANT	0	3,308,481	215,219		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	199,440	376	446,939	8.00
9.00	00900	HOUSEKEEPING	0	1,328,487	1,581	0	213,262
10.00	01000	DIETARY	0	71,542	5,958	0	5,958
11.00	01100	CAFETERIA	0	525,796	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	77,423	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93,425	0	0	0
15.00	01500	PHARMACY	0	983,916	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	319,751	1,956	0	1,956
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	32,433	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	29,971	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,391,264	55,346	69,570	55,346
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	1,546,223	5,415	122,537	5,415
43.00	04300	NURSERY	0	490,210	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	7,550,036	33,058	79,921	33,058
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,108,722	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,400,695	11,169	41,540	11,169
54.01	05401	ULTRA SOUND	0	287,609	340	0	340
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,186,037	8,540	5,681	8,540
60.00	06000	LABORATORY	0	849,925	4,064	0	4,064
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	338,282	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	996,470	1,355	0	1,355
66.00	06600	PHYSICAL THERAPY	0	1,713,697	5,236	8,669	5,236
67.00	06700	OCCUPATIONAL THERAPY	0	180,077	0	3,698	0
68.00	06800	SPEECH PATHOLOGY	0	5,583	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	438,583	2,689	0	2,689
70.00	07000	ELECTROENCEPHALOGRAPHY	0	250,952	3,632	2,699	3,632
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,585,280	1,224	0	1,224
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	12,076,575	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,687,056	2,572	0	2,572
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	496,945	0	2,919	0
90.01	09001	WOUND CARE INSTITUTE	0	30,336	0	63	0
90.02	09002	OP NUTRITIONAL COUNSELING	0	27,285	0	0	0
90.03	09003	BARITRIC MEDICINE	0	0	0	0	0
90.04	04950	MARKETING & PLANNING	0	0	0	0	0
91.00	09100	EMERGENCY	0	3,569,729	14,694	86,569	14,694
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-29,182,284	58,178,236	159,205	423,866	157,248
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	126,130	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,584,634	51,027	333	51,027
194.00	07950	COMMUNITY RELATIONS & MARKETING	0	1,171,504	0	0	0
194.01	07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	783,007	0	0	0
194.02	07952	JV MV ENDOSCOPY	0	3,579,637	4,987	22,740	4,987
194.03	07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	224,457	0	0	0
194.04	07954	OTHER NRCC	0	173	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)		29,182,284	4,779,193	296,447	1,954,145
203.00		Unit cost multiplier (Wkst. B, Part I)		0.444528	22.206185	0.663283	9.163119
204.00		Cost to be allocated (per Wkst. B, Part II)		172,092	1,133,842	12,635	55,249
205.00		Unit cost multiplier (Wkst. B, Part II)		0.002621	5.268317	0.028270	0.259066

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet B-1 Date/Time Prepared: 5/26/2015 3:59 pm		
Cost Center Description	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
	10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00570	ADMITTING					5.01
5.02 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03 00590	OTHER ADMIN & GENERAL					5.03
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	9,323				10.00
11.00 01100	CAFETERIA	0	505,338			11.00
13.00 01300	NURSING ADMINISTRATION	0	2,474	297,393		13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	4,884	0	16,177,698	14.00
15.00 01500	PHARMACY	0	19,628	0	10,914	100 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,714	61,789	61,789	21,808	0 30.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	970	32,328	32,328	3,421	0 34.00
43.00 04300	NURSERY	639	20,936	20,936	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	64,805	64,805	75,097	0 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	47,364	47,364	0	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	51,161	0	17,140	0 54.00
54.01 05401	ULTRA SOUND	0	5,269	0	2	0 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	11,789	0	44,069	0 55.00
60.00 06000	LABORATORY	0	0	0	0	0 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
64.00 06400	INTRAVENOUS THERAPY	0	319	0	5,076	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	25,584	0	1,450	0 65.00
66.00 06600	PHYSICAL THERAPY	0	41,277	0	8,605	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	6,008	0	3,562	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	77	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	1,510	0	50,437	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	3,453	0	2,360	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,238,229	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	11,569,429	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	14,033	0	2,680	0 90.00
90.01 09001	WOUND CARE INSTITUTE	0	784	0	33	0 90.01
90.02 09002	OP NUTRITIONAL COUNSELING	0	728	0	0	0 90.02
90.03 09003	BARITRIC MEDICINE	0	0	0	0	0 90.03
90.04 04950	MARKETING & PLANNING	0	0	0	0	0 90.04
91.00 09100	EMERGENCY	0	70,171	70,171	23,596	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,323	486,371	297,393	16,077,908	100 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,542	0	77,136	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	4,576	0	14,237	0 192.00
194.00 07950	COMMUNITY RELATIONS & MARKETING	0	2,439	0	275	0 194.00
194.01 07951	PLAINFIELD RADIOLOGY & PHYSICAL THER	0	8,401	0	8,142	0 194.01
194.02 07952	JV MV ENDOSCOPY	0	0	0	0	0 194.02
194.03 07953	SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0	0	0 194.03
194.04 07954	OTHER NRCC	0	9	0	0	0 194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	290,242	759,527	115,558	142,296	1,450,891 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	31.131825	1.503008	0.388570	0.008796	14,508.910000 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	193,268	1,693	277	340	3,467 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	14.707069	0.003350	0.000931	0.000021	34.670000 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

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

Worksheet B-1
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
		16.00	21.00		
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00570 ADMITTING					5.01
5.02 00580 CASHIERING/ACCOUNTS RECEIVABLE					5.02
5.03 00590 OTHER ADMIN & GENERAL					5.03
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	312,257,058				16.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	100			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		100		22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	12,012,076	100	100		30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	2,119,173	0	0		34.00
43.00 04300 NURSERY	1,059,032	0	0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	26,685,951	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,394,467	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	47,664,719	0	0		54.00
54.01 05401 ULTRA SOUND	4,472,859	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	8,832,169	0	0		55.00
60.00 06000 LABORATORY	27,661,858	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	2,247,331	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	4,297,822	0	0		65.00
66.00 06600 PHYSICAL THERAPY	8,862,991	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	955,260	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	119,479	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	7,184,271	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2,771,897	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22,716,674	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	30,934,194	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	34,798,951	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	3,190,256	0	0		90.00
90.01 09001 WOUND CARE INSTITUTE	195,123	0	0		90.01
90.02 09002 OP NUTRITIONAL COUNSELING	66,577	0	0		90.02
90.03 09003 BARIATRIC MEDICINE	0	0	0		90.03
90.04 04950 MARKETING & PLANNING	0	0	0		90.04
91.00 09100 EMERGENCY	61,013,928	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910 CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	312,257,058	100	100	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00 07950 COMMUNITY RELATIONS & MARKETING	0	0	0		194.00
194.01 07951 PLAINFIELD RADIOLOGY & PHYSICAL THER	0	0	0		194.01
194.02 07952 JV MV ENDOSCOPY	0	0	0		194.02
194.03 07953 SOUTHWEST CENTER FOR WOMENS HEALTH	0	0	0		194.03
194.04 07954 OTHER NRCC	0	0	0		194.04
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	523,247	46,850	43,294	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.001676	468.500000	432.940000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	64,182	85	79	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150057

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

Worksheet B-1
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description		INTERNS & RESIDENTS			
		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		16.00	21.00	22.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000206	0.850000	0.790000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150057

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2015 3:59 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	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,392,026		11,392,026	0	11,392,026	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,579,633		2,579,633	0	2,579,633	34.00
43.00	04300	NURSERY	769,392		769,392	0	769,392	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,164,224		12,164,224	520	12,164,744	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,695,185		1,695,185	0	1,695,185	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,002,720		4,002,720	16,824	4,019,544	54.00
54.01	05401	ULTRA SOUND	441,540		441,540	0	441,540	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,462,364		3,462,364	0	3,462,364	55.00
60.00	06000	LABORATORY	1,401,586		1,401,586	0	1,401,586	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	492,949		492,949	0	492,949	64.00
65.00	06500	RESPIRATORY THERAPY	1,527,603	0	1,527,603	10,915	1,538,518	65.00
66.00	06600	PHYSICAL THERAPY	2,722,453	0	2,722,453	0	2,722,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	273,241	0	273,241	0	273,241	67.00
68.00	06800	SPEECH PATHOLOGY	8,381	0	8,381	0	8,381	68.00
69.00	06900	ELECTROCARDIOLOGY	732,652		732,652	0	732,652	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	488,087		488,087	0	488,087	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,737,313		6,737,313	0	6,737,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,598,569		17,598,569	0	17,598,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,915,952		6,915,952	0	6,915,952	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	746,250		746,250	0	746,250	90.00
90.01	09001	WOUND CARE INSTITUTE	45,368		45,368	0	45,368	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	40,620		40,620	0	40,620	90.02
90.03	09003	BARIATRIC MEDICINE	0		0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0		0	0	0	90.04
91.00	09100	EMERGENCY	5,910,039		5,910,039	0	5,910,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	738,846		738,846	0	738,846	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	82,886,993	0	82,886,993	28,259	82,915,252	200.00
201.00		Less Observation Beds	738,846		738,846		738,846	201.00
202.00		Total (see instructions)	82,148,147	0	82,148,147	28,259	82,176,406	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150057

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2015 3:59 pm

		Title XVII I			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,043,151		11,043,151		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,119,173		2,119,173		34.00
43.00	04300	NURSERY	1,059,032		1,059,032		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,933,835	8,752,116	26,685,951	0.455829	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,369,479	24,988	2,394,467	0.707959	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,963,348	44,701,371	47,664,719	0.083977	54.00
54.01	05401	ULTRA SOUND	253,339	4,219,520	4,472,859	0.098715	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	53,554	8,778,615	8,832,169	0.392017	55.00
60.00	06000	LABORATORY	5,506,366	22,155,492	27,661,858	0.050669	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	266,616	1,980,715	2,247,331	0.219349	64.00
65.00	06500	RESPIRATORY THERAPY	2,973,087	1,324,735	4,297,822	0.355437	65.00
66.00	06600	PHYSICAL THERAPY	2,480,041	6,382,950	8,862,991	0.307171	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,148	610,112	955,260	0.286038	67.00
68.00	06800	SPEECH PATHOLOGY	117,076	2,403	119,479	0.070146	68.00
69.00	06900	ELECTROCARDIOLOGY	448,337	6,735,934	7,184,271	0.101980	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,771,897	2,771,897	0.176084	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,239,480	6,477,194	22,716,674	0.296580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	28,231,380	2,702,814	30,934,194	0.568903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,538,976	24,259,975	34,798,951	0.198740	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,447	3,185,809	3,190,256	0.233915	90.00
90.01	09001	WOUND CARE INSTITUTE	3,320	191,803	195,123	0.232510	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	66,577	66,577	0.610121	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0.000000	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	4,905,060	56,108,868	61,013,928	0.096864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	260,138	708,787	968,925	0.762542	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	110,114,383	202,142,675	312,257,058		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	110,114,383	202,142,675	312,257,058		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/26/2015 3:59 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.455848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707959	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084330	54.00
54.01	05401	ULTRA SOUND	0.098715	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.392017	55.00
60.00	06000	LABORATORY	0.050669	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0.219349	64.00
65.00	06500	RESPIRATORY THERAPY	0.357976	65.00
66.00	06600	PHYSICAL THERAPY	0.307171	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.286038	67.00
68.00	06800	SPEECH PATHOLOGY	0.070146	68.00
69.00	06900	ELECTROCARDIOLOGY	0.101980	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.176084	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.296580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.568903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198740	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.233915	90.00
90.01	09001	WOUND CARE INSTITUTE	0.232510	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.610121	90.02
90.03	09003	BARIATRIC MEDICINE	0.000000	90.03
90.04	04950	MARKETING & PLANNING	0.000000	90.04
91.00	09100	EMERGENCY	0.096864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.762542	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF		99.10
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: 150057

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2015 3:59 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	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,392,026		11,392,026	0	11,392,026	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,579,633		2,579,633	0	2,579,633	34.00
43.00	04300	NURSERY	769,392		769,392	0	769,392	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,164,224		12,164,224	520	12,164,744	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,695,185		1,695,185	0	1,695,185	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,002,720		4,002,720	16,824	4,019,544	54.00
54.01	05401	ULTRA SOUND	441,540		441,540	0	441,540	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,462,364		3,462,364	0	3,462,364	55.00
60.00	06000	LABORATORY	1,401,586		1,401,586	0	1,401,586	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	492,949		492,949	0	492,949	64.00
65.00	06500	RESPIRATORY THERAPY	1,527,603	0	1,527,603	10,915	1,538,518	65.00
66.00	06600	PHYSICAL THERAPY	2,722,453	0	2,722,453	0	2,722,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	273,241	0	273,241	0	273,241	67.00
68.00	06800	SPEECH PATHOLOGY	8,381	0	8,381	0	8,381	68.00
69.00	06900	ELECTROCARDIOLOGY	732,652		732,652	0	732,652	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	488,087		488,087	0	488,087	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,737,313		6,737,313	0	6,737,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,598,569		17,598,569	0	17,598,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,915,952		6,915,952	0	6,915,952	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	746,250		746,250	0	746,250	90.00
90.01	09001	WOUND CARE INSTITUTE	45,368		45,368	0	45,368	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	40,620		40,620	0	40,620	90.02
90.03	09003	BARIATRIC MEDICINE	0		0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0		0	0	0	90.04
91.00	09100	EMERGENCY	5,910,039		5,910,039	0	5,910,039	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	738,846		738,846	0	738,846	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	82,886,993	0	82,886,993	28,259	82,915,252	200.00
201.00		Less Observation Beds	738,846		738,846		738,846	201.00
202.00		Total (see instructions)	82,148,147	0	82,148,147	28,259	82,176,406	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150057

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2015 3:59 pm

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,043,151		11,043,151		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,119,173		2,119,173		34.00
43.00	04300	NURSERY	1,059,032		1,059,032		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,933,835	8,752,116	26,685,951	0.455829	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,369,479	24,988	2,394,467	0.707959	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,963,348	44,701,371	47,664,719	0.083977	54.00
54.01	05401	ULTRA SOUND	253,339	4,219,520	4,472,859	0.098715	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	53,554	8,778,615	8,832,169	0.392017	55.00
60.00	06000	LABORATORY	5,506,366	22,155,492	27,661,858	0.050669	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	266,616	1,980,715	2,247,331	0.219349	64.00
65.00	06500	RESPIRATORY THERAPY	2,973,087	1,324,735	4,297,822	0.355437	65.00
66.00	06600	PHYSICAL THERAPY	2,480,041	6,382,950	8,862,991	0.307171	66.00
67.00	06700	OCCUPATIONAL THERAPY	345,148	610,112	955,260	0.286038	67.00
68.00	06800	SPEECH PATHOLOGY	117,076	2,403	119,479	0.070146	68.00
69.00	06900	ELECTROCARDIOLOGY	448,337	6,735,934	7,184,271	0.101980	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,771,897	2,771,897	0.176084	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,239,480	6,477,194	22,716,674	0.296580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	28,231,380	2,702,814	30,934,194	0.568903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,538,976	24,259,975	34,798,951	0.198740	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,447	3,185,809	3,190,256	0.233915	90.00
90.01	09001	WOUND CARE INSTITUTE	3,320	191,803	195,123	0.232510	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	66,577	66,577	0.610121	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0.000000	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	4,905,060	56,108,868	61,013,928	0.096864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	260,138	708,787	968,925	0.762542	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	110,114,383	202,142,675	312,257,058		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	110,114,383	202,142,675	312,257,058		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/26/2015 3:59 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.455848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707959	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084330	54.00
54.01	05401	ULTRA SOUND	0.098715	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.392017	55.00
60.00	06000	LABORATORY	0.050669	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0.219349	64.00
65.00	06500	RESPIRATORY THERAPY	0.357976	65.00
66.00	06600	PHYSICAL THERAPY	0.307171	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.286038	67.00
68.00	06800	SPEECH PATHOLOGY	0.070146	68.00
69.00	06900	ELECTROCARDIOLOGY	0.101980	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.176084	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.296580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.568903	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198740	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.233915	90.00
90.01	09001	WOUND CARE INSTITUTE	0.232510	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.610121	90.02
90.03	09003	BARIATRIC MEDICINE	0.000000	90.03
90.04	04950	MARKETING & PLANNING	0.000000	90.04
91.00	09100	EMERGENCY	0.096864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.762542	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF		99.10
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 150057

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

Worksheet C Part II Date/Time Prepared: 5/26/2015 3:59 pm

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,164,224	1,112,405	11,051,819	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,695,185	6,126	1,689,059	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,002,720	382,554	3,620,166	0	0	54.00
54.01	05401	ULTRA SOUND	441,540	13,095	428,445	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,462,364	284,704	3,177,660	0	0	55.00
60.00	06000	LABORATORY	1,401,586	143,248	1,258,338	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	492,949	1,546	491,403	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,527,603	50,302	1,477,301	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,722,453	179,236	2,543,217	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	273,241	1,172	272,069	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,381	122	8,259	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	732,652	90,091	642,561	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	488,087	119,056	369,031	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,737,313	67,370	6,669,943	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,598,569	57,360	17,541,209	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,915,952	110,695	6,805,257	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	746,250	2,515	743,735	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	45,368	152	45,216	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	40,620	112	40,508	0	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	5,910,039	506,027	5,404,012	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	738,846	125,684	613,162	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	68,145,942	3,253,572	64,892,370	0	0	200.00
201.00		Less Observation Beds	738,846	125,684	613,162	0	0	201.00
202.00		Total (line 200 minus line 201)	67,407,096	3,127,888	64,279,208	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Prepared: 5/26/2015 3:59 pm
		Title XIX	Hospital	PPS

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	12,164,224	26,685,951	0.455829	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,695,185	2,394,467	0.707959	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,002,720	47,664,719	0.083977	54.00
54.01	05401 ULTRA SOUND	441,540	4,472,859	0.098715	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	3,462,364	8,832,169	0.392017	55.00
60.00	06000 LABORATORY	1,401,586	27,661,858	0.050669	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	60.01
64.00	06400 INTRAVENOUS THERAPY	492,949	2,247,331	0.219349	64.00
65.00	06500 RESPIRATORY THERAPY	1,527,603	4,297,822	0.355437	65.00
66.00	06600 PHYSICAL THERAPY	2,722,453	8,862,991	0.307171	66.00
67.00	06700 OCCUPATIONAL THERAPY	273,241	955,260	0.286038	67.00
68.00	06800 SPEECH PATHOLOGY	8,381	119,479	0.070146	68.00
69.00	06900 ELECTROCARDIOLOGY	732,652	7,184,271	0.101980	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	488,087	2,771,897	0.176084	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6,737,313	22,716,674	0.296580	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	17,598,569	30,934,194	0.568903	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,915,952	34,798,951	0.198740	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	746,250	3,190,256	0.233915	90.00
90.01	09001 WOUND CARE INSTITUTE	45,368	195,123	0.232510	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	40,620	66,577	0.610121	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0.000000	90.03
90.04	04950 MARKETING & PLANNING	0	0	0.000000	90.04
91.00	09100 EMERGENCY	5,910,039	61,013,928	0.096864	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	738,846	968,925	0.762542	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF	0	0	0.000000	99.10
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	68,145,942	298,035,702		200.00
201.00	Less Observation Beds	738,846	0		201.00
202.00	Total (line 200 minus line 201)	67,407,096	298,035,702		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/26/2015 3:59 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
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,937,870	0	1,937,870	8,249	234.92	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	200,333		200,333	970	206.53	34.00
43.00	NURSERY	12,114		12,114	639	18.96	43.00
200.00	Total (Lines 30-199)	2,150,317		2,150,317	9,858		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,632	1,088,149				
34.00	SURGICAL INTENSIVE CARE UNIT	659	136,103				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	5,291	1,224,252				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/26/2015 3:59 pm
		Title XVIIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,112,405	26,685,951	0.041685	8,409,753	350,561	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,126	2,394,467	0.002558	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	382,554	47,664,719	0.008026	1,491,676	11,972	54.00
54.01	05401 ULTRA SOUND	13,095	4,472,859	0.002928	102,549	300	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	284,704	8,832,169	0.032235	21,266	686	55.00
60.00	06000 LABORATORY	143,248	27,661,858	0.005179	2,528,333	13,094	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	1,546	2,247,331	0.000688	152,201	105	64.00
65.00	06500 RESPIRATORY THERAPY	50,302	4,297,822	0.011704	1,616,367	18,918	65.00
66.00	06600 PHYSICAL THERAPY	179,236	8,862,991	0.020223	1,900,876	38,441	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,172	955,260	0.001227	184,488	226	67.00
68.00	06800 SPEECH PATHOLOGY	122	119,479	0.001021	30,099	31	68.00
69.00	06900 ELECTROCARDIOLOGY	90,091	7,184,271	0.012540	275,001	3,449	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	119,056	2,771,897	0.042951	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	67,370	22,716,674	0.002966	7,596,040	22,530	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	57,360	30,934,194	0.001854	13,833,829	25,648	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	110,695	34,798,951	0.003181	5,080,757	16,162	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	2,515	3,190,256	0.000788	616	0	90.00
90.01	09001 WOUND CARE INSTITUTE	152	195,123	0.000779	1,889	1	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	112	66,577	0.001682	0	0	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0.000000	0	0	90.03
90.04	04950 MARKETING & PLANNING	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	506,027	61,013,928	0.008294	2,297,753	19,058	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	125,684	968,925	0.129715	144,445	18,737	92.00
200.00	Total (lines 50-199)	3,253,572	298,035,702		45,667,938	539,919	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/26/2015 3:59 pm	
Title XVIII			Hospital		PPS			
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,249	0.00	4,632	0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	970	0.00	659	0		34.00
43.00	04300	NURSERY	639	0.00	0	0		43.00
200.00		Total (lines 30-199)	9,858		5,291	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150057

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

Worksheet D
Part IV
Date/Time Prepared:
5/26/2015 3:59 pm

Cost Center Description		Title XVIII				Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 3:59 pm
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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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	26,685,951	0.000000	0.000000	8,409,753	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,394,467	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	47,664,719	0.000000	0.000000	1,491,676	54.00
54.01	05401 ULTRA SOUND	0	4,472,859	0.000000	0.000000	102,549	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	8,832,169	0.000000	0.000000	21,266	55.00
60.00	06000 LABORATORY	0	27,661,858	0.000000	0.000000	2,528,333	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	2,247,331	0.000000	0.000000	152,201	64.00
65.00	06500 RESPIRATORY THERAPY	0	4,297,822	0.000000	0.000000	1,616,367	65.00
66.00	06600 PHYSICAL THERAPY	0	8,862,991	0.000000	0.000000	1,900,876	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	955,260	0.000000	0.000000	184,488	67.00
68.00	06800 SPEECH PATHOLOGY	0	119,479	0.000000	0.000000	30,099	68.00
69.00	06900 ELECTROCARDIOLOGY	0	7,184,271	0.000000	0.000000	275,001	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,771,897	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,716,674	0.000000	0.000000	7,596,040	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	30,934,194	0.000000	0.000000	13,833,829	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	34,798,951	0.000000	0.000000	5,080,757	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	3,190,256	0.000000	0.000000	616	90.00
90.01	09001 WOUND CARE INSTITUTE	0	195,123	0.000000	0.000000	1,889	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0	66,577	0.000000	0.000000	0	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0.000000	0.000000	0	90.03
90.04	04950 MARKETING & PLANNING	0	0	0.000000	0.000000	0	90.04
91.00	09100 EMERGENCY	0	61,013,928	0.000000	0.000000	2,297,753	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	968,925	0.000000	0.000000	144,445	92.00
200.00	Total (lines 50-199)	0	298,035,702			45,667,938	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 3:59 pm
	Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0	2,171,876	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	17,457,007	0	54.00
54.01	05401 ULTRA SOUND	0	1,461,697	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	4,134,496	0	55.00
60.00	06000 LABORATORY	0	2,966,667	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	545,911	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	494,032	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,000,759	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	595,756	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,637,455	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,363,942	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	16,312,367	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	1,641,257	0	90.00
90.01	09001 WOUND CARE INSTITUTE	0	131,346	0	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0	0	0	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0	90.03
90.04	04950 MARKETING & PLANNING	0	0	0	90.04
91.00	09100 EMERGENCY	0	10,721,260	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	192,919	0	92.00
200.00	Total (lines 50-199)	0	64,828,747	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 3:59 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.455829	2,171,876	0	0	990,004	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.707959	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.083977	17,457,007	0	0	1,465,987	54.00
54.01 05401 ULTRA SOUND	0.098715	1,461,697	0	0	144,291	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.392017	4,134,496	0	0	1,620,793	55.00
60.00 06000 LABORATORY	0.050669	2,966,667	0	0	150,318	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0.219349	545,911	0	0	119,745	64.00
65.00 06500 RESPIRATORY THERAPY	0.355437	494,032	0	0	175,597	65.00
66.00 06600 PHYSICAL THERAPY	0.307171	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.286038	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.070146	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.101980	3,000,759	0	0	306,017	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.176084	595,756	0	0	104,903	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.296580	1,637,455	3,198	0	485,636	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.568903	1,363,942	0	0	775,951	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.198740	16,312,367	9,331	0	3,241,920	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.233915	1,641,257	0	0	383,915	90.00
90.01 09001 WOUND CARE INSTITUTE	0.232510	131,346	0	0	30,539	90.01
90.02 09002 OP NUTRITIONAL COUNSELING	0.610121	0	0	0	0	90.02
90.03 09003 BARIATRIC MEDICINE	0.000000	0	0	0	0	90.03
90.04 04950 MARKETING & PLANNING	0.000000	0	0	0	0	90.04
91.00 09100 EMERGENCY	0.096864	10,721,260	0	0	1,038,504	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.762542	192,919	0	0	147,109	92.00
200.00 Subtotal (see instructions)		64,828,747	12,529	0	11,181,229	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		64,828,747	12,529	0	11,181,229	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 3:59 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRA SOUND	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	948	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,854	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOUND CARE INSTITUTE	0	0		90.01
90.02 09002 OP NUTRITIONAL COUNSELING	0	0		90.02
90.03 09003 BARIATRIC MEDICINE	0	0		90.03
90.04 04950 MARKETING & PLANNING	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	2,802	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	2,802	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/26/2015 3:59 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	1,937,870	0	1,937,870	8,249	234.92	30.00
34.00	SURGICAL INTENSIVE CARE UNIT	200,333		200,333	970	206.53	34.00
43.00	NURSERY	12,114		12,114	639	18.96	43.00
200.00	Total (Lines 30-199)	2,150,317		2,150,317	9,858		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	241	56,616				
34.00	SURGICAL INTENSIVE CARE UNIT	31	6,402				
43.00	NURSERY	20	379				
200.00	Total (Lines 30-199)	292	63,397				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/26/2015 3:59 pm
Title XIX			Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,112,405	26,685,951	0.041685	673,088	28,058	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,126	2,394,467	0.002558	1,055,726	2,701	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	382,554	47,664,719	0.008026	177,614	1,426	54.00
54.01	05401 ULTRA SOUND	13,095	4,472,859	0.002928	26,324	77	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	284,704	8,832,169	0.032235	0	0	55.00
60.00	06000 LABORATORY	143,248	27,661,858	0.005179	471,822	2,444	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	1,546	2,247,331	0.000688	15,237	10	64.00
65.00	06500 RESPIRATORY THERAPY	50,302	4,297,822	0.011704	206,751	2,420	65.00
66.00	06600 PHYSICAL THERAPY	179,236	8,862,991	0.020223	99,672	2,016	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,172	955,260	0.001227	10,961	13	67.00
68.00	06800 SPEECH PATHOLOGY	122	119,479	0.001021	726	1	68.00
69.00	06900 ELECTROCARDIOLOGY	90,091	7,184,271	0.012540	25,788	323	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	119,056	2,771,897	0.042951	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	67,370	22,716,674	0.002966	746,997	2,216	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	57,360	30,934,194	0.001854	691,164	1,281	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	110,695	34,798,951	0.003181	599,378	1,907	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	2,515	3,190,256	0.000788	445	0	90.00
90.01	09001 WOUND CARE INSTITUTE	152	195,123	0.000779	0	0	90.01
90.02	09002 OP NUTRITIONAL COUNSELING	112	66,577	0.001682	0	0	90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0.000000	0	0	90.03
90.04	04950 MARKETING & PLANNING	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	506,027	61,013,928	0.008294	260,115	2,157	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	125,684	968,925	0.129715	9,169	1,189	92.00
200.00	Total (lines 50-199)	3,253,572	298,035,702		5,070,977	48,239	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/26/2015 3:59 pm	
Title XIX			Hospital		PPS			
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,249	0.00	241	0		30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	970	0.00	31	0		34.00
43.00	04300	NURSERY	639	0.00	20	0		43.00
200.00		Total (lines 30-199)	9,858		292	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 3:59 pm
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Cost Center Description	Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col . 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRA SOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE INSTITUTE	0	0	0	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	0	0	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 3:59 pm
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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		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	26,685,951	0.000000	0.000000	673,088	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,394,467	0.000000	0.000000	1,055,726	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,664,719	0.000000	0.000000	177,614	54.00
54.01	05401	ULTRA SOUND	0	4,472,859	0.000000	0.000000	26,324	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	8,832,169	0.000000	0.000000	0	55.00
60.00	06000	LABORATORY	0	27,661,858	0.000000	0.000000	471,822	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	2,247,331	0.000000	0.000000	15,237	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,297,822	0.000000	0.000000	206,751	65.00
66.00	06600	PHYSICAL THERAPY	0	8,862,991	0.000000	0.000000	99,672	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	955,260	0.000000	0.000000	10,961	67.00
68.00	06800	SPEECH PATHOLOGY	0	119,479	0.000000	0.000000	726	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,184,271	0.000000	0.000000	25,788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,771,897	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,716,674	0.000000	0.000000	746,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	30,934,194	0.000000	0.000000	691,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,798,951	0.000000	0.000000	599,378	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	3,190,256	0.000000	0.000000	445	90.00
90.01	09001	WOUND CARE INSTITUTE	0	195,123	0.000000	0.000000	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0	66,577	0.000000	0.000000	0	90.02
90.03	09003	BARIATRIC MEDICINE	0	0	0.000000	0.000000	0	90.03
90.04	04950	MARKETING & PLANNING	0	0	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	61,013,928	0.000000	0.000000	260,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	968,925	0.000000	0.000000	9,169	92.00
200.00		Total (lines 50-199)	0	298,035,702			5,070,977	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 3:59 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401 ULTRA SOUND	0	0	0		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 WOUND CARE INSTITUTE	0	0	0		90.01
90.02	09002 OP NUTRITIONAL COUNSELING	0	0	0		90.02
90.03	09003 BARIATRIC MEDICINE	0	0	0		90.03
90.04	04950 MARKETING & PLANNING	0	0	0		90.04
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 3:59 pm
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.455829	0	407,021	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.707959	0	16,932	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.083977	0	4,753,580	0	0
54.01 05401 ULTRA SOUND	0.098715	0	833,936	0	0
55.00 05500 RADIOLOGY-THERAPEUTIC	0.392017	0	188,059	0	0
60.00 06000 LABORATORY	0.050669	0	2,629,938	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.219349	0	1,842	0	0
65.00 06500 RESPIRATORY THERAPY	0.355437	0	177,211	0	0
66.00 06600 PHYSICAL THERAPY	0.307171	0	734,109	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.286038	0	76,339	0	0
68.00 06800 SPEECH PATHOLOGY	0.070146	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.101980	0	462,017	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.176084	0	494,842	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.296580	0	534,596	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.568903	0	149,371	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.198740	0	682,234	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.233915	0	198,724	0	0
90.01 09001 WOUND CARE INSTITUTE	0.232510	0	3,914	0	0
90.02 09002 OP NUTRITIONAL COUNSELING	0.610121	0	11,196	0	0
90.03 09003 BARIATRIC MEDICINE	0.000000	0	0	0	0
90.04 04950 MARKETING & PLANNING	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.096864	0	13,515,199	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.762542	0	90,827	0	0
200.00 Subtotal (see instructions)		0	25,961,887	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	25,961,887	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/26/2015 3:59 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	185,532	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	11,987	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	399,191	0		54.00
54.01 05401 ULTRA SOUND	82,322	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	73,722	0		55.00
60.00 06000 LABORATORY	133,256	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	404	0		64.00
65.00 06500 RESPIRATORY THERAPY	62,987	0		65.00
66.00 06600 PHYSICAL THERAPY	225,497	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	21,836	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	47,116	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	87,134	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	158,550	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	84,978	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	135,587	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	46,485	0		90.00
90.01 09001 WOUND CARE INSTITUTE	910	0		90.01
90.02 09002 OP NUTRITIONAL COUNSELING	6,831	0		90.02
90.03 09003 BARIATRIC MEDICINE	0	0		90.03
90.04 04950 MARKETING & PLANNING	0	0		90.04
91.00 09100 EMERGENCY	1,309,136	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	69,259	0		92.00
200.00 Subtotal (see instructions)	3,142,720	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	3,142,720	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/26/2015 3:59 pm
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,249	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,249	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)		7,714	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)		4,632	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		11,392,026	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		11,392,026	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		11,392,026	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,381.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,396,885	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)		6,396,885	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 3:59 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)	0	0	0.00	0	0	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	2,579,633	970	2,659.42	659	1,752,558	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)					16,850,746	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,000,189	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)					1,224,252	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					539,919	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,764,171	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,236,018	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)					535	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,381.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					738,846	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 3:59 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	1,937,870	11,392,026	0.170108	738,846	125,684	90.00
91.00	Nursing School cost	0	11,392,026	0.000000	738,846	0	91.00
92.00	Allied health cost	0	11,392,026	0.000000	738,846	0	92.00
93.00	All other Medical Education	0	11,392,026	0.000000	738,846	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/26/2015 3:59 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,249	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,249	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)		7,714	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)		241	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)		639	15.00
16.00	Nursery days (title V or XIX only)		20	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		11,392,026	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		11,392,026	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		11,392,026	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,381.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		332,826	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)		332,826	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 3:59 pm	
Title XIX			Hospital	PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	769,392	639	1,204.06	20	24,081	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	2,579,633	970	2,659.42	31	82,442	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)					1,975,668	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,415,017	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)					63,397	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					48,239	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					111,636	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,303,381	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)					535	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,381.02	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					738,846	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150057		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 3:59 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	1,937,870	11,392,026	0.170108	738,846	125,684	90.00
91.00	Nursing School cost	0	11,392,026	0.000000	738,846	0	91.00
92.00	Allied health cost	0	11,392,026	0.000000	738,846	0	92.00
93.00	All other Medical Education	0	11,392,026	0.000000	738,846	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 3:59 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		5,311,380	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		1,116,465	34.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.455848	8,409,753	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707959	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084330	1,491,676	54.00
54.01	05401	ULTRA SOUND	0.098715	102,549	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.392017	21,266	55.00
60.00	06000	LABORATORY	0.050669	2,528,333	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.219349	152,201	64.00
65.00	06500	RESPIRATORY THERAPY	0.357976	1,616,367	65.00
66.00	06600	PHYSICAL THERAPY	0.307171	1,900,876	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.286038	184,488	67.00
68.00	06800	SPEECH PATHOLOGY	0.070146	30,099	68.00
69.00	06900	ELECTROCARDIOLOGY	0.101980	275,001	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.176084	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.296580	7,596,040	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.568903	13,833,829	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198740	5,080,757	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.233915	616	90.00
90.01	09001	WOUND CARE INSTITUTE	0.232510	1,889	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.610121	0	90.02
90.03	09003	BARIATRIC MEDICINE	0.000000	0	90.03
90.04	04950	MARKETING & PLANNING	0.000000	0	90.04
91.00	09100	EMERGENCY	0.096864	2,297,753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.762542	144,445	92.00
200.00		Total (sum of lines 50-94 and 96-98)		45,667,938	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		45,667,938	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 3:59 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		789,964	30.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		146,455	34.00
43.00	04300	NURSERY		554,153	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.455848	673,088	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.707959	1,055,726	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084330	177,614	54.00
54.01	05401	ULTRA SOUND	0.098715	26,324	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.392017	0	55.00
60.00	06000	LABORATORY	0.050669	471,822	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.219349	15,237	64.00
65.00	06500	RESPIRATORY THERAPY	0.357976	206,751	65.00
66.00	06600	PHYSICAL THERAPY	0.307171	99,672	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.286038	10,961	67.00
68.00	06800	SPEECH PATHOLOGY	0.070146	726	68.00
69.00	06900	ELECTROCARDIOLOGY	0.101980	25,788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.176084	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.296580	746,997	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.568903	691,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198740	599,378	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.233915	445	90.00
90.01	09001	WOUND CARE INSTITUTE	0.232510	0	90.01
90.02	09002	OP NUTRITIONAL COUNSELING	0.610121	0	90.02
90.03	09003	BARIATRIC MEDICINE	0.000000	0	90.03
90.04	04950	MARKETING & PLANNING	0.000000	0	90.04
91.00	09100	EMERGENCY	0.096864	260,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.762542	9,169	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,070,977	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		5,070,977	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/26/2015 3:59 pm
		Title XVII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		9,170,215	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,331,388	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		113,692	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		3,574,344	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		96.53	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.63	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.63	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.38	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.38	12.00
13.00	Total allowable FTE count for the prior year.		0.46	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.34	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.39	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.39	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.004040	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.004661	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.004040	21.00
22.00	IME payment adjustment (see instructions)		35,464	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-0.25	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		35,464	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.57	30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		1.57	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/26/2015 3:59 pm	
		Title XVII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000046473	0.000033721	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		12,650,759		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		12,650,759		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,007,562		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		25,866		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		13,684,187		59.00
60.00	Primary payer payments		3,261		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,680,926		61.00
62.00	Deductibles billed to program beneficiaries		1,366,560		62.00
63.00	Coinurance billed to program beneficiaries		2,432		63.00
64.00	Allowable bad debts (see instructions)		73,642		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		47,867		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,216		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,359,801		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		43,683		70.93
70.94	HRR adjustment amount (see instructions)		0		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/26/2015 3:59 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,403,484		71.00
71.01	Sequestration adjustment (see instructions)		248,070		71.01
72.00	Interim payments		12,138,994		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		16,420		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		108,186		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1 1.00	On/After 10/1 2.00	
100.00	HSP Bonus Payment Amount HSP bonus amount (see instructions)		0		100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0		102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0		104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/26/2015 3:59 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,802	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		11,181,229	2.00
3.00	PPS payments		9,053,444	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,802	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		12,529	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		12,529	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)		12,529	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,727	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)		2,802	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)		9,053,444	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		640	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,964,723	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		7,090,883	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		11,572	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		7,102,455	30.00
31.00	Primary payer payments		1,090	31.00
32.00	Subtotal (line 30 minus line 31)		7,101,365	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		176,031	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		114,420	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		75,340	36.00
37.00	Subtotal (see instructions)		7,215,785	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS		39	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,215,824	40.00
40.01	Sequestration adjustment (see instructions)		144,316	40.01
41.00	Interim payments		7,030,623	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		40,885	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: 150057

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2015 3:59 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12,103,694		6,982,423	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/14/2014	35,300	08/14/2014	48,200	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)		35,300		48,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		12,138,994		7,030,623	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		16,420		40,885	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		12,155,414		7,071,508	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/26/2015 3:59 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			2,941 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			5,291 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,234 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			8,684 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			312,257,058 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			19,486,941 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			472,506 8.00
9.00	Sequestration adjustment amount (see instructions)			9,450 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			463,056 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			351,038 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			112,018 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2015 3:59 pm	
		Title XIX	Hospital	PPS	
			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		0		1.00
2.00	Medical and other services			3,142,720	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	3,142,720	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)		0	3,142,720	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		5,070,977	25,961,887	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)		5,070,977	25,961,887	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)		5,070,977	25,961,887	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		5,070,977	22,819,167	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	3,142,720	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	0	24.00
25.00	Capital exception payments (see instructions)		0	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	3,142,720	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	3,142,720	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	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	3,142,720	36.00
37.00	OTHER ADJ - TO ZERO OUT MEDICAID		0	-3,142,720	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	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/26/2015 3:59 pm	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.63	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.63	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.38	6.00
7.00	Enter the lesser of line 5 or line 6			0.38	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.38	0.38	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.38	0.38	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	0.00	0.38		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.80	0.38		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.34	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.38	0.25		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	0.38	0.25		17.00
18.00	Per resident amount	81,830.02	81,830.02		18.00
19.00	Approved amount for resident costs	31,095	20,458	51,553	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			51,553	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	5,291	1,234		26.00
27.00	Total Inpatient Days (see instructions)	8,745	8,745		27.00
28.00	Ratio of inpatient days to total inpatient days	0.605031	0.141109		28.00
29.00	Program direct GME amount	31,191	7,275		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		1,028		30.00
31.00	Net Program direct GME amount			37,438	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/26/2015 3:59 pm
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		25,000,189	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		3,261	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		24,996,928	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		11,184,031	42.00
43.00	Primary payer payments (see instructions)		1,090	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		11,182,941	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		36,179,869	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.690907	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.309093	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		37,438	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		25,866	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		11,572	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet G Date/Time Prepared: 5/26/2015 3:59 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	858,318	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	44,228,606	0	0	0	4.00
5.00	Other receivable	551,930	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-31,488,463	0	0	0	6.00
7.00	Inventory	3,194,712	0	0	0	7.00
8.00	Prepaid expenses	366,073	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	931	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,712,107	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	1,432,719	0	0	0	13.00
14.00	Accumulated depreciation	-551,347	0	0	0	14.00
15.00	Buildings	80,974,988	0	0	0	15.00
16.00	Accumulated depreciation	-31,161,275	0	0	0	16.00
17.00	Leasehold improvements	592,542	0	0	0	17.00
18.00	Accumulated depreciation	-228,026	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	23,384,057	0	0	0	23.00
24.00	Accumulated depreciation	-8,998,791	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)	65,444,867	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,425,882	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)	1,425,882	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	84,582,856	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,196,013	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,187,763	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	322,421	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,706,197	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	-1,934,216	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-1,934,216	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,771,981	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	79,810,875	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	79,810,875	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	84,582,856	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150057

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

Worksheet G-1

Date/Time Prepared:
5/26/2015 3:59 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		85,526,625			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		26,509,605				2.00
3.00	Total (sum of line 1 and line 2)		112,036,230			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		112,036,230			0	11.00
12.00	FUND EQUITY CHANGES	34,237,558		0		0	12.00
13.00	PBC OUT OF BALANCE	-2,012,203		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		32,225,355			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		79,810,875			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	FUND EQUITY CHANGES		0				12.00
13.00	PBC OUT OF BALANCE		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: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2015 3:59 pm
Cost Center Description		Inpatient	Outpatient	Total
		1.00	2.00	3.00
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00	Hospital	18,729,792		18,729,792
2.00	SUBPROVIDER - IPF			
3.00	SUBPROVIDER - IRF			
4.00	SUBPROVIDER			
5.00	Swing bed - SNF	0		0
6.00	Swing bed - NF	0		0
7.00	SKILLED NURSING FACILITY			
8.00	NURSING FACILITY			
9.00	OTHER LONG TERM CARE			
10.00	Total general inpatient care services (sum of lines 1-9)	18,729,792		18,729,792
Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT			
12.00	CORONARY CARE UNIT			
13.00	BURN INTENSIVE CARE UNIT			
14.00	SURGICAL INTENSIVE CARE UNIT	0		0
15.00	OTHER SPECIAL CARE (SPECIFY)			
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,729,792		18,729,792
18.00	Ancillary services	89,091,637	140,556,992	229,648,629
19.00	Outpatient services	4,854,574	60,024,063	64,878,637
20.00	RURAL HEALTH CLINIC	0	0	0
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0
22.00	HOME HEALTH AGENCY			
23.00	AMBULANCE SERVICES			
24.00	CMHC			
24.10	CORF	0	0	0
25.00	AMBULATORY SURGICAL CENTER (D.P.)			
26.00	HOSPICE			
27.00	OTHER	1,045	6,921,757	6,922,802
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	112,677,048	207,502,812	320,179,860
PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		87,276,250	
30.00	ADD (SPECIFY)	0		
31.00		0		
32.00		0		
33.00		0		
34.00		0		
35.00		0		
36.00	Total additions (sum of lines 30-35)		0	
37.00	DEDUCT (SPECIFY)	0		
38.00		0		
39.00		0		
40.00		0		
41.00		0		
42.00	Total deductions (sum of lines 37-41)		0	
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		87,276,250	

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150057

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

Worksheet G-3

Date/Time Prepared:
5/26/2015 3:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	320,179,860	1.00
2.00	Less contractual allowances and discounts on patients' accounts	212,210,047	2.00
3.00	Net patient revenues (line 1 minus line 2)	107,969,813	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	87,276,250	4.00
5.00	Net income from service to patients (line 3 minus line 4)	20,693,563	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	110	7.00
8.00	Revenues from telephone and other miscellaneous communication services	501,716	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	623,923	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	675,157	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	350	20.00
21.00	Rental of vending machines	157,748	21.00
22.00	Rental of hospital space	36,716	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - IDENTIFIED ON TRIAL BALANCE	3,820,322	24.00
25.00	Total other income (sum of lines 6-24)	5,816,042	25.00
26.00	Total (line 5 plus line 25)	26,509,605	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	26,509,605	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150057	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/26/2015 3:59 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		999,461	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,503	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		23.96	3.00
4.00	Number of interns & residents (see instructions)		0.39	4.00
5.00	Indirect medical education percentage (see instructions)		0.46	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		4,598	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,007,562	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00