This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151330	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/28/2015 11:12 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2015 Time: 11:12 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 ADAMS MEMORIAL HOSPITAL (151330) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	115,084	-379,022	0	0	1.00
2.00	Subprovider - IPF	0	9	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	9,246	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	124,339	-379,022	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 7:55 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1100 MERCER AVENEUE	PO Box:			1.00
2.00	City: DECATUR	State: IN	Zip Code: 46733	County: ADAMS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ADAMS MEMORIAL HOSPITAL	151330	99915	1	11/01/2005	N	O	P	3.00
4.00	Subprovider - IPF	ADAMS MEMORIAL HOSPITAL	15M330	99915	4	11/01/2005	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ADAMS MEMORIAL HOSPITAL	15Z330	99915		11/01/2005	N	O	P	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	9		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		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.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 7:55 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(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	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 7:55 am

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 7:55 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	N		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2015 7:55 am

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	80,538	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: 151330	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 7:55 am

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H060	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: ADAMS HEALTH NETWORK	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1100 MERCER AVE	PO Box:		142.00
143.00	City: DECATUR	State: IN	Zip Code: 46733	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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus 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	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151330	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 7:55 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2015 7:55 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		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)		Y	05/05/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2015 7:55 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed 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				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	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.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	WADE	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500	WADEH@BRADLEYCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2015 7:55 am

		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)	05/05/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		PARTNER		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

VOLUNTARY CONTACT INFORMATION	Provider CCN: 151330	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part V Date/Time Prepared: 5/28/2015 7:55 am

		1.00	
	Cost Report Preparer Contact Information		
1.00	First Name	WADE	1.00
2.00	Last Name	HILL	2.00
3.00	Title	PARTNER	3.00
4.00	Employer	BRADLEY ASSOCIATES	4.00
5.00	Phone Number	(317)237-5500	5.00
6.00	E-mail Address	WADEH@BRADELYCPA.COM	6.00
7.00	Department		7.00
8.00	Mailing Address 1	201 S CAPITOL AVE	8.00
9.00	Mailing Address 2	SUITE 700	9.00
10.00	City	INDIANAPOLIS	10.00
11.00	State	IN	11.00
12.00	Zip	46225	12.00
	Officer or Administrator of Provider Contact Information		
13.00	First Name	DANE	13.00
14.00	Last Name	WHEELER	14.00
15.00	Title	CFO	15.00
16.00	Employer	ADAMS HEALTH NETWORK	16.00
17.00	Phone Number	(260)724-2145	17.00
18.00	E-mail Address	DWHEELER@ADAMSHOSPITAL.COM	18.00
19.00	Department		19.00
20.00	Mailing Address 1	1100 MERCER AVE	20.00
21.00	Mailing Address 2	PO BOX 151	21.00
22.00	City	DECATUR	22.00
23.00	State	IN	23.00
24.00	Zip	46733	24.00

HFS Supplemental Information | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part IX | Date/Time Prepared: 5/28/2015 7:55 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2015 7:55 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips 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	21	7,665	116,952.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	116,952.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	20,064.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	137,016.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		35				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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2015 7:55 am

	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)	2,334	244	4,803			1.00
2.00	HMO and other (see instructions)	893	0				2.00
3.00	HMO IPF Subprovider	80	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	24	0	24			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	132			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,358	244	4,959			7.00
8.00	INTENSIVE CARE UNIT	377	31	836			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		21	403			13.00
14.00	Total (see instructions)	2,735	296	6,198	0.00	348.92	14.00
15.00	CAH visits	36,967	9,550	97,721			15.00
16.00	SUBPROVIDER - IPF	600	290	1,857	0.00	14.22	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	363.14	27.00
28.00	Observation Bed Days		0	887			28.00
29.00	Ambulance Trips	867					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	70			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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2015 7:55 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	604	90	1,512	1.00
2.00	HMO and other (see instructions)			205	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	604	90	1,512	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	96	58	388	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/28/2015 7:55 am

		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)	0.413314	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	986,299	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,656,488	6.00
7.00	Medicaid cost (line 1 times line 6)	2,751,220	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)	1,764,921	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	100,000	9.00
10.00	Stand-alone SCHIP charges	200,000	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	82,663	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)	1,764,921	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	1,737,735	0	1,737,735	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	718,230	0	718,230	21.00
22.00	Partial payment by patients approved for charity care	935,867	0	935,867	22.00
23.00	Cost of charity care (line 21 minus line 22)	-217,637	0	-217,637	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)	5,694,500	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	83,054	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,611,446	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,319,289	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,101,652	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,866,573	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/28/2015 7:55 am

		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		2,585,317	2,585,317	67,097	2,652,414	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
2.01	00201	OTHER CAP		67,545	67,545	0	67,545	2.01
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,510,793	5,510,793	0	5,510,793	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	802,343	6,106,280	6,908,623	-63,073	6,845,550	5.00
7.00	00700	OPERATION OF PLANT	457,202	960,340	1,417,542	0	1,417,542	7.00
7.01	00701	BIO-MEDICAL	55,910	40,856	96,766	0	96,766	7.01
7.02	00702	UTILITIES - HOSPITAL	0	779,140	779,140	5,257	784,397	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	94,878	94,878	-5,257	89,621	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	45,583	132,514	178,097	0	178,097	8.00
9.00	00900	HOUSEKEEPING	374,308	88,731	463,039	0	463,039	9.00
10.00	01000	DIETARY	571,751	684,050	1,255,801	-970,177	285,624	10.00
11.00	01100	CAFETERIA	0	0	0	970,177	970,177	11.00
13.00	01300	NURSING ADMINISTRATION	807,677	85,565	893,242	0	893,242	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	659,252	112,849	772,101	0	772,101	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	335,303	323,368	658,671	0	658,671	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,106,837	307,921	2,414,758	369,751	2,784,509	30.00
31.00	03100	INTENSIVE CARE UNIT	573,405	37,889	611,294	0	611,294	31.00
40.00	04000	SUBPROVIDER - IPF	952,911	144,569	1,097,480	-231,012	866,468	40.00
43.00	04300	NURSERY	0	0	0	193,723	193,723	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,121	1,121	0	1,121	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,974,708	786,814	2,761,522	0	2,761,522	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	622,989	50,084	673,073	-563,474	109,599	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	932,900	767,296	1,700,196	0	1,700,196	54.00
60.00	06000	LABORATORY	1,005,651	1,728,922	2,734,573	0	2,734,573	60.00
65.00	06500	RESPIRATORY THERAPY	599,066	108,302	707,368	0	707,368	65.00
66.00	06600	PHYSICAL THERAPY	634,221	42,287	676,508	0	676,508	66.00
67.00	06700	OCCUPATIONAL THERAPY	174,573	17,422	191,995	0	191,995	67.00
68.00	06800	SPEECH PATHOLOGY	120,221	9,634	129,855	0	129,855	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,240,076	1,240,076	0	1,240,076	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	641,962	641,962	0	641,962	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,473,461	1,473,461	0	1,473,461	73.00
76.00	03020	OP PSYCH	0	0	0	240,551	240,551	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	863,295	116,057	979,352	0	979,352	90.00
90.01	09001	CLINIC - AMO	834,070	42,859	876,929	0	876,929	90.01
90.02	09002	CLINIC - AMH NEURO	25,822	9,063	34,885	0	34,885	90.02
90.03	09003	CLINIC - NIGLIAZZO	1,093,309	148,151	1,241,460	0	1,241,460	90.03
91.00	09100	EMERGENCY	2,051,500	223,078	2,274,578	0	2,274,578	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,086,662	129,005	1,215,667	0	1,215,667	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,761,469	25,598,199	45,359,668	13,563	45,373,231	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	687,579	164,748	852,327	0	852,327	194.01
194.02	07952	OTHER MOBS	239,548	297,703	537,251	-13,563	523,688	194.02
194.03	07953	MONROE	362,974	48,183	411,157	0	411,157	194.03
200.00		TOTAL (SUM OF LINES 118-199)	21,051,570	26,108,833	47,160,403	0	47,160,403	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/28/2015 7:55 am

		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	-141,884	2,510,530		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
2.01	00201	OTHER CAP	0	67,545		2.01
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-520,879	4,989,914		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	162,634	7,008,184		5.00
7.00	00700	OPERATION OF PLANT	0	1,417,542		7.00
7.01	00701	BIO-MEDICAL	0	96,766		7.01
7.02	00702	UTILITIES - HOSPITAL	0	784,397		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	89,621		7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,097		8.00
9.00	00900	HOUSEKEEPING	0	463,039		9.00
10.00	01000	DIETARY	0	285,624		10.00
11.00	01100	CAFETERIA	-420,144	550,033		11.00
13.00	01300	NURSING ADMINISTRATION	0	893,242		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	772,101		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,583	634,088		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-685,686	2,098,823		30.00
31.00	03100	INTENSIVE CARE UNIT	0	611,294		31.00
40.00	04000	SUBPROVIDER - IPF	-128,692	737,776		40.00
43.00	04300	NURSERY	0	193,723		43.00
44.00	04400	SKILLED NURSING FACILITY	-1,121	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-984,131	1,777,391		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	109,599		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,700,196		54.00
60.00	06000	LABORATORY	-53,726	2,680,847		60.00
65.00	06500	RESPIRATORY THERAPY	-79,428	627,940		65.00
66.00	06600	PHYSICAL THERAPY	0	676,508		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	191,995		67.00
68.00	06800	SPEECH PATHOLOGY	0	129,855		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,240,076		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	641,962		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-9,972	1,463,489		73.00
76.00	03020	OP PSYCH	0	240,551		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-567,020	412,332		90.00
90.01	09001	CLINIC - AMO	-508,973	367,956		90.01
90.02	09002	CLINIC - AMH NEURO	0	34,885		90.02
90.03	09003	CLINIC - NIGLIAZZO	-787,503	453,957		90.03
91.00	09100	EMERGENCY	-1,031,339	1,243,239		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	1,215,667		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,782,447	39,590,784		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	852,327		194.01
194.02	07952	OTHER MOBS	0	523,688		194.02
194.03	07953	MONROE	0	411,157		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-5,782,447	41,377,956		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet Non-CMS W | Date/Time Prepared: 5/28/2015 7:55 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
2.01	OTHER CAP	00201		2.01
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
7.01	BIO-MEDICAL	00701		7.01
7.02	UTILITIES - HOSPITAL	00702		7.02
7.03	UTILITIES - OFFSITE BLDGS	00703		7.03
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	OP PSYCH	03020	ACUPUNCTURE	76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
90.01	CLINIC - AMO	09001		90.01
90.02	CLINIC - AMH NEURO	09002		90.02
90.03	CLINIC - NIGLIAZZO	09003		90.03
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	09500		95.00
97.00	DURABLE MEDICAL EQUIP-SOLD	09700		97.00
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
194.00	TITLE XX	07950		194.00
194.01	OTHER NRCC	07951		194.01
194.02	OTHER MOBS	07952		194.02
194.03	MONROE	07953		194.03
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/28/2015 7:55 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - OB, NURSERY AND L&D				
1.00	ADULTS & PEDIATRICS	30.00	342,237	27,514	1.00
2.00	NURSERY	43.00	179,308	14,415	2.00
	TOTALS		521,545	41,929	
	B - INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	67,097	1.00
	TOTALS		0	67,097	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	441,710	528,467	1.00
	TOTALS		441,710	528,467	
	D - O/P PSYCH				
1.00	OP PSYCH	76.00	200,581	30,431	1.00
	TOTALS		200,581	30,431	
	E - HOSPITAL USE OF SWISS CITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,024	1.00
2.00	OP PSYCH	76.00	0	9,539	2.00
3.00	UTILITIES - HOSPITAL	7.02	0	5,257	3.00
	TOTALS		0	18,820	
500.00	Grand Total: Increases		1,163,836	686,744	500.00

RECLASSIFICATIONS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/28/2015 7:55 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - OB, NURSERY AND L&D						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	521,545	41,929	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		521,545	41,929			
	B - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	67,097	12		1.00
	TOTALS		0	67,097			
	C - CAFETERIA						
1.00	DIETARY	10.00	441,710	528,467	0		1.00
	TOTALS		441,710	528,467			
	D - O/P PSYCH						
1.00	SUBPROVIDER - IPF	40.00	200,581	30,431	0		1.00
	TOTALS		200,581	30,431			
	E - HOSPITAL USE OF SWISS CITY						
1.00	OTHER MOBS	194.02	0	13,563	0		1.00
2.00	UTILITIES - OFFSITE BLDGS	7.03	0	5,257	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	18,820			
500.00	Grand Total: Decreases		1,163,836	686,744			500.00

RECLASSIFICATIONS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/28/2015 7:55 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - OB, NURSERY AND L&D								
1.00	ADULTS & PEDIATRICS	30.00	342,237	27,514	DELIVERY ROOM & LABOR ROOM	52.00	521,545	41,929	1.00
2.00	NURSERY	43.00	179,308	14,415		0.00	0	0	2.00
	TOTALS		521,545	41,929	TOTALS		521,545	41,929	
	B - INSURANCE								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	67,097	ADMINISTRATIVE & GENERAL	5.00	0	67,097	1.00
	TOTALS		0	67,097	TOTALS		0	67,097	
	C - CAFETERIA								
1.00	CAFETERIA	11.00	441,710	528,467	DIETARY	10.00	441,710	528,467	1.00
	TOTALS		441,710	528,467	TOTALS		441,710	528,467	
	D - O/P PSYCH								
1.00	OP PSYCH	76.00	200,581	30,431	SUBPROVIDER - IPF	40.00	200,581	30,431	1.00
	TOTALS		200,581	30,431	TOTALS		200,581	30,431	
	E - HOSPITAL USE OF SWISS CITY								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,024	OTHER MOBS	194.02	0	13,563	1.00
2.00	OP PSYCH	76.00	0	9,539	UTILITIES - OFFSITE BLDGS	7.03	0	5,257	2.00
3.00	UTILITIES - HOSPITAL	7.02	0	5,257		0.00	0	0	3.00
	TOTALS		0	18,820	TOTALS		0	18,820	
500.00	Grand Total: Increases		1,163,836	686,744	Grand Total: Decreases		1,163,836	686,744	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I Date/Time Prepared: 5/28/2015 7:55 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	360,100	0	0	0	545	1.00
2.00	Land Improvements	1,530,852	27,441	0	27,441	0	2.00
3.00	Buildings and Fixtures	37,653,083	464,999	0	464,999	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,309,794	84,222	0	84,222	0	5.00
6.00	Movable Equipment	20,925,295	630,053	0	630,053	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,779,124	1,206,715	0	1,206,715	545	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	64,779,124	1,206,715	0	1,206,715	545	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	359,555	0	1.00
2.00	Land Improvements	1,558,293	0	2.00
3.00	Buildings and Fixtures	38,118,082	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,394,016	0	5.00
6.00	Movable Equipment	21,555,348	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,985,294	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	65,985,294	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2015 7:55 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,585,317	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	67,545	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,652,862	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	2,585,317	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
2.01	OTHER CAP	0	67,545	2.01
3.00	Total (sum of lines 1-2)	0	2,652,862	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2015 7:55 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
2.01	OTHER CAP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	2,443,433	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	0	0	0	67,545	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,510,978	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	67,097	0	0	2,510,530	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	0	0	0	0	67,545	2.01
3.00	Total (sum of lines 1-2)	0	67,097	0	0	2,578,075	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/28/2015 7:55 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-141,884	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	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
2.01	Investment income - OTHER CAP (chapter 2)		0	OTHER CAP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-7,441	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,064,025			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	-427,450			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-420,144	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-9,972	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-24,583	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - OTHER CAP		0	OTHER CAP	2.01	0	27.01
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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/28/2015 7:55 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	IHA DUES	A	-809	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	AHA DUES	A	-3,375	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00			0		0.00	0	35.00
36.00			0		0.00	0	36.00
37.00	JAY COUNTY MGT FEES	B	-17,169	SUBPROVIDER - IPF	40.00	0	37.00
38.00			0		0.00	0	38.00
39.00	WORTHMAN FITNESS CENTER	B	-79,428	RESPIRATORY THERAPY	65.00	0	39.00
40.00	MISC INCOME	B	-67,266	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	NONALLOWABLE PHYSICIAN BENEFITS	A	-354,410	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00			0		0.00	0	42.00
43.00			0		0.00	0	43.00
44.00	ECU RUN-OFF EXPENSES	A	-1,121	SKILLED NURSING FACILITY	44.00	0	44.00
45.02	HOSPITAL PROVIDER TAX	A	668,975	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.06	CRNA FEES	A	-665,876	OPERATING ROOM	50.00	0	45.06
45.07	CRNA BENEFITS	A	-166,469	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,782,447				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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/28/2015 7:55 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	AHN- A&G	1,767,075	2,194,525	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	1,767,075	2,194,525	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151330	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/28/2015 7:55 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	-427,450	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-427,450			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	MANAGEMENT		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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2015 7:55 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	SUBPROVIDER - IPF	111,523	111,523	0	0	0	1.00
2.00	60.00	LABORATORY	55,000	53,726	1,274	0	0	2.00
3.00	91.00	EMERGENCY	1,310,071	1,016,091	293,980	0	0	3.00
4.00	91.00	EMERGENCY	158,333	15,248	143,085	0	0	4.00
5.00	90.00	CLINIC	567,020	567,020	0	0	0	5.00
6.00	90.01	CLINIC - AMO	490,333	490,333	0	0	0	6.00
7.00	90.03	CLINIC - NIGLIAZZO	787,503	787,503	0	0	0	7.00
8.00	50.00	OPERATING ROOM	309,365	309,365	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	685,686	685,686	0	0	0	9.00
10.00	50.00	OPERATING ROOM	100,000	8,890	91,110	0	0	10.00
11.00	90.01	CLINIC - AMO	18,640	18,640	0	0	0	11.00
200.00			4,593,474	4,064,025	529,449		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	CLINIC - AMO	0	0	0	0	0	6.00
7.00	90.03	CLINIC - NIGLIAZZO	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	9.00
10.00	50.00	OPERATING ROOM	0	0	0	0	0	10.00
11.00	90.01	CLINIC - AMO	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	SUBPROVIDER - IPF	0	0	0	111,523		1.00
2.00	60.00	LABORATORY	0	0	0	53,726		2.00
3.00	91.00	EMERGENCY	0	0	0	1,016,091		3.00
4.00	91.00	EMERGENCY	0	0	0	15,248		4.00
5.00	90.00	CLINIC	0	0	0	567,020		5.00
6.00	90.01	CLINIC - AMO	0	0	0	490,333		6.00
7.00	90.03	CLINIC - NIGLIAZZO	0	0	0	787,503		7.00
8.00	50.00	OPERATING ROOM	0	0	0	309,365		8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	685,686		9.00
10.00	50.00	OPERATING ROOM	0	0	0	8,890		10.00
11.00	90.01	CLINIC - AMO	0	0	0	18,640		11.00
200.00			0	0	0	4,064,025		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW MVBLE EQUIP	OTHER CAP		
			0	1.00	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,510,530	2,510,530				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
2.01	00201	OTHER CAP	67,545		0	67,545		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,989,914	0	0	0	4,989,914	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,008,184	308,786	0	9,285	242,562	5.00
7.00	00700	OPERATION OF PLANT	1,417,542	381,581	0	8,391	138,220	7.00
7.01	00701	BIO-MEDICAL	96,766	9,205	0	199	16,903	7.01
7.02	00702	UTILITIES - HOSPITAL	784,397	0	0	0	0	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	89,621	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	178,097	36,503	0	791	13,781	8.00
9.00	00900	HOUSEKEEPING	463,039	49,698	0	1,259	113,160	9.00
10.00	01000	DIETARY	285,624	14,779	0	320	39,314	10.00
11.00	01100	CAFETERIA	550,033	132,035	0	2,861	133,536	11.00
13.00	01300	NURSING ADMINISTRATION	893,242	12,393	0	268	244,174	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	772,101	33,463	0	725	199,303	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	634,088	53,604	0	1,161	101,368	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,098,823	410,693	0	8,898	533,104	30.00
31.00	03100	INTENSIVE CARE UNIT	611,294	68,066	0	1,475	173,350	31.00
40.00	04000	SUBPROVIDER - IPF	737,776	150,931	0	3,270	227,442	40.00
43.00	04300	NURSERY	193,723	5,278	0	114	54,208	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,777,391	231,495	0	5,015	302,156	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	109,599	0	0	0	30,669	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,700,196	186,948	0	4,050	282,032	54.00
60.00	06000	LABORATORY	2,680,847	67,812	0	1,796	304,025	60.00
65.00	06500	RESPIRATORY THERAPY	627,940	86,328	0	1,870	181,108	65.00
66.00	06600	PHYSICAL THERAPY	676,508	73,365	0	1,589	191,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	191,995	2,111	0	46	52,776	67.00
68.00	06800	SPEECH PATHOLOGY	129,855	1,056	0	23	36,345	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,240,076	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	641,962	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,463,489	0	0	0	0	73.00
76.00	03020	OP PSYCH	240,551	0	0	0	60,639	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	412,332	0	0	2,006	89,569	90.00
90.01	09001	CLINIC - AMO	367,956	0	0	894	103,918	90.01
90.02	09002	CLINIC - AMH NEURO	34,885	0	0	0	7,806	90.02
90.03	09003	CLINIC - NIGLIAZZO	453,957	0	0	1,063	89,763	90.03
91.00	09100	EMERGENCY	1,243,239	114,153	0	2,473	308,412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,215,667	0	0	1,977	328,516	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,590,784	2,430,283	0	61,819	4,599,895	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,807	0	299	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	852,327	66,440	0	3,179	207,867	194.01
194.02	07952	OTHER MOBS	523,688	0	0	1,464	72,419	194.02
194.03	07953	MONROE	411,157	0	0	784	109,733	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,377,956	2,510,530	0	67,545	4,989,914	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	
			4A	5.00	7.00	7.01	7.02	
		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
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,568,817	7,568,817				5.00
7.00	00700	OPERATION OF PLANT	1,945,734	435,590	2,381,324			7.00
7.01	00701	BIO-MEDICAL	123,073	27,552	9,522	160,147		7.01
7.02	00702	UTILITIES - HOSPITAL	784,397	175,602	0	0	959,999	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	89,621	20,063	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	229,172	51,305	37,762	0	19,350	8.00
9.00	00900	HOUSEKEEPING	627,156	140,401	60,126	0	26,345	9.00
10.00	01000	DIETARY	340,037	76,124	15,288	0	7,834	10.00
11.00	01100	CAFETERIA	818,465	183,229	136,589	0	69,993	11.00
13.00	01300	NURSING ADMINISTRATION	1,150,077	257,467	12,820	0	6,570	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,005,592	225,121	34,617	0	17,739	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	790,221	176,906	55,452	0	28,416	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,051,518	683,140	424,856	28,094	217,711	30.00
31.00	03100	INTENSIVE CARE UNIT	854,185	191,226	70,413	624	36,082	31.00
40.00	04000	SUBPROVIDER - IPF	1,119,419	250,603	156,136	51	80,009	40.00
43.00	04300	NURSERY	253,323	56,711	5,460	209	2,798	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,316,057	518,493	239,478	41,275	122,717	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	140,268	31,402	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,173,226	486,518	193,395	66,134	99,102	54.00
60.00	06000	LABORATORY	3,054,480	683,799	85,745	7,490	35,948	60.00
65.00	06500	RESPIRATORY THERAPY	897,246	200,866	89,305	8,287	45,763	65.00
66.00	06600	PHYSICAL THERAPY	943,198	211,153	75,895	3,103	38,891	66.00
67.00	06700	OCCUPATIONAL THERAPY	246,928	55,280	2,184	0	1,119	67.00
68.00	06800	SPEECH PATHOLOGY	167,279	37,449	1,092	0	560	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,240,076	277,615	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	641,962	143,715	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,463,489	327,630	0	0	0	73.00
76.00	03020	OP PSYCH	301,190	67,427	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	503,907	112,809	95,791	66	0	90.00
90.01	09001	CLINIC - AMO	472,768	105,838	42,698	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	42,691	9,557	0	287	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	544,783	121,960	50,778	581	0	90.03
91.00	09100	EMERGENCY	1,668,277	373,476	118,090	895	60,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,546,160	346,137	94,415	2,707	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,114,792	7,062,164	2,107,907	159,803	917,460	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,106	3,158	14,283	0	7,319	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	1,129,813	252,930	151,811	344	35,220	194.01
194.02	07952	OTHER MOBS	597,571	133,778	69,889	0	0	194.02
194.03	07953	MONROE	521,674	116,787	37,434	0	0	194.03
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,377,956	7,568,817	2,381,324	160,147	959,999	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.03	8.00	9.00	10.00	11.00	
		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
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	109,684					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	337,589				8.00
9.00	00900	HOUSEKEEPING	0	62,378	916,406			9.00
10.00	01000	DIETARY	0	3,349	6,161	448,793		10.00
11.00	01100	CAFETERIA	0	11,378	55,046	0	1,274,700	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,167	0	58,085	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	13,951	0	35,274	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	22,348	0	39,708	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	56,705	171,222	291,791	187,692	30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,602	28,377	48,739	47,361	31.00
40.00	04000	SUBPROVIDER - IPF	0	10,171	62,924	108,263	71,600	40.00
43.00	04300	NURSERY	0	0	2,200	0	13,667	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	53,891	96,512	0	92,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,783	0	0	7,733	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,678	77,940	0	82,424	54.00
60.00	06000	LABORATORY	0	182	34,556	0	108,715	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,956	35,990	0	59,252	65.00
66.00	06600	PHYSICAL THERAPY	0	18,204	30,586	0	74,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	880	0	35,881	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	440	0	10,415	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020	OP PSYCH	0	2,712	0	0	19,089	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,815	38,605	0	44,894	90.00
90.01	09001	CLINIC - AMO	387	59	17,207	0	27,679	90.01
90.02	09002	CLINIC - AMH NEURO	0	15	0	0	2,624	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	818	20,464	0	24,503	90.03
91.00	09100	EMERGENCY	0	41,503	47,591	0	62,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	10,213	14,566	38,050	0	123,465	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,600	335,765	806,217	448,793	1,229,903	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,756	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	783	1,119	61,181	0	44,797	194.01
194.02	07952	OTHER MOBS	98,301	51	28,166	0	0	194.02
194.03	07953	MONROE	0	654	15,086	0	0	194.03
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)	109,684	337,589	916,406	448,793	1,274,700	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		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
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
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	1,490,186					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	1,332,294			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,113,051		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	578,948	0	0	369,723	6,061,400	30.00
31.00	03100	INTENSIVE CARE UNIT	146,085	0	0	35,556	1,471,250	31.00
40.00	04000	SUBPROVIDER - IPF	220,852	0	0	73,746	2,153,774	40.00
43.00	04300	NURSERY	42,158	0	0	2,456	378,982	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	286,391	0	0	100,656	3,868,318	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,852	0	0	0	211,038	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,095	3,219,512	54.00
60.00	06000	LABORATORY	0	0	0	0	4,010,915	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,405	1,355,070	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,395,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	342,272	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	217,235	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,517,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	785,677	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,332,294	0	3,123,413	73.00
76.00	03020	OP PSYCH	0	0	0	19,662	410,080	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,001	801,888	90.00
90.01	09001	CLINIC - AMO	0	0	0	6,973	673,609	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	1,552	56,726	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	6,230	770,117	90.03
91.00	09100	EMERGENCY	191,900	0	0	459,304	3,023,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	2,175,713	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,490,186	0	1,332,294	1,101,359	38,024,253	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	44,622	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	8,588	1,686,586	194.01
194.02	07952	OTHER MOBS	0	0	0	983	928,739	194.02
194.03	07953	MONROE	0	0	0	2,121	693,756	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,490,186	0	1,332,294	1,113,051	41,377,956	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/28/2015 7:55 am

		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
2.01	00201	OTHER CAP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	BIO-MEDICAL				7.01
7.02	00702	UTILITIES - HOSPITAL				7.02
7.03	00703	UTILITIES - OFFSITE BLDGS				7.03
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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	6,061,400		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,471,250		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,153,774		40.00
43.00	04300	NURSERY	0	378,982		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,868,318		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	211,038		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,219,512		54.00
60.00	06000	LABORATORY	0	4,010,915		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,355,070		65.00
66.00	06600	PHYSICAL THERAPY	0	1,395,810		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	342,272		67.00
68.00	06800	SPEECH PATHOLOGY	0	217,235		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,517,691		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	785,677		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,123,413		73.00
76.00	03020	OP PSYCH	0	410,080		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	801,888		90.00
90.01	09001	CLINIC - AMO	0	673,609		90.01
90.02	09002	CLINIC - AMH NEURO	0	56,726		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	770,117		90.03
91.00	09100	EMERGENCY	0	3,023,763		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,175,713		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	38,024,253		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44,622		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	1,686,586		194.01
194.02	07952	OTHER MOBS	0	928,739		194.02
194.03	07953	MONROE	0	693,756		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	41,377,956		202.00

COST ALLOCATION STATISTICS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet Non-CMS W | Date/Time Prepared: 5/28/2015 7:55 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
2.01	OTHER CAP	30	SQUARE FEET	2.01
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	30	SQUARE FEET	7.00
7.01	BIO-MEDICAL	32	COST	7.01
7.02	UTILITIES - HOSPITAL	1	SQUARE FEET	7.02
7.03	UTILITIES - OFFSITE BLDGS	33	COST	7.03
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	30	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	CAPITAL RELATED COSTS OTHER CAP	CAPITAL RELATED COSTS Subtotal	
			0	1.00	2.00	2.01	2A	
		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
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	69,880	308,786	0	9,285	387,951	5.00
7.00	00700	OPERATION OF PLANT	0	381,581	0	8,391	389,972	7.00
7.01	00701	BIO-MEDICAL	0	9,205	0	199	9,404	7.01
7.02	00702	UTILITIES - HOSPITAL	0	0	0	0	0	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,503	0	791	37,294	8.00
9.00	00900	HOUSEKEEPING	0	49,698	0	1,259	50,957	9.00
10.00	01000	DIETARY	0	14,779	0	320	15,099	10.00
11.00	01100	CAFETERIA	0	132,035	0	2,861	134,896	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,393	0	268	12,661	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	33,463	0	725	34,188	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53,604	0	1,161	54,765	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	410,693	0	8,898	419,591	30.00
31.00	03100	INTENSIVE CARE UNIT	0	68,066	0	1,475	69,541	31.00
40.00	04000	SUBPROVIDER - IPF	0	150,931	0	3,270	154,201	40.00
43.00	04300	NURSERY	0	5,278	0	114	5,392	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	231,495	0	5,015	236,510	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	186,948	0	4,050	190,998	54.00
60.00	06000	LABORATORY	0	67,812	0	1,796	69,608	60.00
65.00	06500	RESPIRATORY THERAPY	0	86,328	0	1,870	88,198	65.00
66.00	06600	PHYSICAL THERAPY	0	73,365	0	1,589	74,954	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,111	0	46	2,157	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,056	0	23	1,079	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,006	2,006	90.00
90.01	09001	CLINIC - AMO	0	0	0	894	894	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	1,063	1,063	90.03
91.00	09100	EMERGENCY	0	114,153	0	2,473	116,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,977	1,977	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,880	2,430,283	0	61,819	2,561,982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,807	0	299	14,106	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	66,440	0	3,179	69,619	194.01
194.02	07952	OTHER MOBS	0	0	0	1,464	1,464	194.02
194.03	07953	MONROE	0	0	0	784	784	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	69,880	2,510,530	0	67,545	2,647,955	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	
			4.00	5.00	7.00	7.01	7.02	
		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
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	387,951				5.00
7.00	00700	OPERATION OF PLANT	0	22,327	412,299			7.00
7.01	00701	BIO-MEDICAL	0	1,412	1,649	12,465		7.01
7.02	00702	UTILITIES - HOSPITAL	0	9,001	0	0	9,001	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	1,028	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,630	6,538	0	181	8.00
9.00	00900	HOUSEKEEPING	0	7,197	10,410	0	247	9.00
10.00	01000	DIETARY	0	3,902	2,647	0	73	10.00
11.00	01100	CAFETERIA	0	9,392	23,649	0	656	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,197	2,220	0	62	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	11,539	5,993	0	166	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,068	9,601	0	266	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	35,016	73,560	2,187	2,044	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,802	12,191	49	338	31.00
40.00	04000	SUBPROVIDER - IPF	0	12,845	27,033	4	750	40.00
43.00	04300	NURSERY	0	2,907	945	16	26	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	26,577	41,463	3,213	1,151	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,610	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,938	33,484	5,146	929	54.00
60.00	06000	LABORATORY	0	35,041	14,846	583	337	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,296	15,462	645	429	65.00
66.00	06600	PHYSICAL THERAPY	0	10,823	13,140	242	365	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,833	378	0	10	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,920	189	0	5	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,230	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,367	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,794	0	0	0	73.00
76.00	03020	OP PSYCH	0	3,456	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,782	16,585	5	0	90.00
90.01	09001	CLINIC - AMO	0	5,425	7,393	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	490	0	22	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	6,251	8,792	45	0	90.03
91.00	09100	EMERGENCY	0	19,143	20,446	70	567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,742	16,347	211	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	361,981	364,961	12,438	8,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	162	2,473	0	69	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	12,965	26,284	27	330	194.01
194.02	07952	OTHER MOBS	0	6,857	12,100	0	0	194.02
194.03	07953	MONROE	0	5,986	6,481	0	0	194.03
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)	0	387,951	412,299	12,465	9,001	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.03	8.00	9.00	10.00	11.00	
		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
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	1,028					7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	46,643				8.00
9.00	00900	HOUSEKEEPING	0	8,619	77,430			9.00
10.00	01000	DIETARY	0	463	521	22,705		10.00
11.00	01100	CAFETERIA	0	1,572	4,651	0	174,816	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	437	0	7,966	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	1,179	0	4,838	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,888	0	5,446	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,835	14,466	14,762	25,740	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,741	2,398	2,466	6,495	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,405	5,317	5,477	9,819	40.00
43.00	04300	NURSERY	0	0	186	0	1,874	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,446	8,155	0	12,733	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,075	0	0	1,061	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,962	6,585	0	11,304	54.00
60.00	06000	LABORATORY	0	25	2,920	0	14,910	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,237	3,041	0	8,126	65.00
66.00	06600	PHYSICAL THERAPY	0	2,515	2,584	0	10,256	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	74	0	4,921	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	37	0	1,428	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020	OP PSYCH	0	375	0	0	2,618	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	251	3,262	0	6,157	90.00
90.01	09001	CLINIC - AMO	4	8	1,454	0	3,796	90.01
90.02	09002	CLINIC - AMH NEURO	0	2	0	0	360	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	113	1,729	0	3,360	90.03
91.00	09100	EMERGENCY	0	5,734	4,021	0	8,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	96	2,013	3,215	0	16,932	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	46,391	68,120	22,705	168,672	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	486	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	7	155	5,169	0	6,144	194.01
194.02	07952	OTHER MOBS	921	7	2,380	0	0	194.02
194.03	07953	MONROE	0	90	1,275	0	0	194.03
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)	1,028	46,643	77,430	22,705	174,816	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		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
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
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	36,543					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	57,903			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	81,034		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,197	0	0	26,917	636,315	30.00
31.00	03100	INTENSIVE CARE UNIT	3,582	0	0	2,589	111,192	31.00
40.00	04000	SUBPROVIDER - IPF	5,416	0	0	5,369	227,636	40.00
43.00	04300	NURSERY	1,034	0	0	179	12,559	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,023	0	0	7,328	351,599	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	585	0	0	0	4,331	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	881	278,227	54.00
60.00	06000	LABORATORY	0	0	0	0	138,270	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	685	128,119	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	114,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	10,373	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	4,658	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	14,230	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	7,367	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	57,903	0	74,697	73.00
76.00	03020	OP PSYCH	0	0	0	1,431	7,880	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	291	34,339	90.00
90.01	09001	CLINIC - AMO	0	0	0	508	19,482	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	113	987	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	454	21,807	90.03
91.00	09100	EMERGENCY	4,706	0	0	33,438	213,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	58,533	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,543	0	57,903	80,183	2,470,763	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	17,296	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	625	121,325	194.01
194.02	07952	OTHER MOBS	0	0	0	72	23,801	194.02
194.03	07953	MONROE	0	0	0	154	14,770	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	36,543	0	57,903	81,034	2,647,955	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/28/2015 7:55 am

		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
2.01	00201	OTHER CAP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	BIO-MEDICAL				7.01
7.02	00702	UTILITIES - HOSPITAL				7.02
7.03	00703	UTILITIES - OFFSITE BLDGS				7.03
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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	636,315		30.00
31.00	03100	INTENSIVE CARE UNIT	0	111,192		31.00
40.00	04000	SUBPROVIDER - IPF	0	227,636		40.00
43.00	04300	NURSERY	0	12,559		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	351,599		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,331		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	278,227		54.00
60.00	06000	LABORATORY	0	138,270		60.00
65.00	06500	RESPIRATORY THERAPY	0	128,119		65.00
66.00	06600	PHYSICAL THERAPY	0	114,879		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,373		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,658		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,230		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	7,367		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	74,697		73.00
76.00	03020	OP PSYCH	0	7,880		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	34,339		90.00
90.01	09001	CLINIC - AMO	0	19,482		90.01
90.02	09002	CLINIC - AMH NEURO	0	987		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	21,807		90.03
91.00	09100	EMERGENCY	0	213,283		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	58,533		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,470,763		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,296		190.00
194.00	07950	TITLE XX	0	0		194.00
194.01	07951	OTHER NRCC	0	121,325		194.01
194.02	07952	OTHER MOBS	0	23,801		194.02
194.03	07953	MONROE	0	14,770		194.03
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	2,647,955		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OTHER CAP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	2.00	2.01	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	118,914					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0				2.00
2.01	00201	OTHER CAP		0	147,670			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	16,505,558		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,626	0	20,292	802,343	-7,568,817	5.00
7.00	00700	OPERATION OF PLANT	18,074	0	18,344	457,202	0	7.00
7.01	00701	BIO-MEDICAL	436	0	436	55,910	0	7.01
7.02	00702	UTILITIES - HOSPITAL	0	0	0	0	0	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	0	0	0	0	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	1,729	0	1,729	45,583	0	8.00
9.00	00900	HOUSEKEEPING	2,354	0	2,753	374,308	0	9.00
10.00	01000	DIETARY	700	0	700	130,041	0	10.00
11.00	01100	CAFETERIA	6,254	0	6,254	441,710	0	11.00
13.00	01300	NURSING ADMINISTRATION	587	0	587	807,677	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,585	0	1,585	659,252	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,539	0	2,539	335,303	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,453	0	19,453	1,763,387	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,224	0	3,224	573,405	0	31.00
40.00	04000	SUBPROVIDER - IPF	7,149	0	7,149	752,330	0	40.00
43.00	04300	NURSERY	250	0	250	179,308	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,965	0	10,965	999,467	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	101,445	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,855	0	8,855	932,900	0	54.00
60.00	06000	LABORATORY	3,212	0	3,926	1,005,651	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,089	0	4,089	599,066	0	65.00
66.00	06600	PHYSICAL THERAPY	3,475	0	3,475	634,221	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	100	174,573	0	67.00
68.00	06800	SPEECH PATHOLOGY	50	0	50	120,221	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020	OP PSYCH	0	0	0	200,581	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	4,386	296,275	0	90.00
90.01	09001	CLINIC - AMO	0	0	1,955	343,737	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	25,822	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	2,325	296,916	0	90.03
91.00	09100	EMERGENCY	5,407	0	5,407	1,020,161	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	4,323	1,086,662	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	115,113	0	135,151	15,215,457	-7,568,817	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	654	0	654	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	3,147	0	6,951	687,579	0	194.01
194.02	07952	OTHER MOBS	0	0	3,200	239,548	0	194.02
194.03	07953	MONROE	0	0	1,714	362,974	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,510,530	0	67,545	4,989,914		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.112148	0.000000	0.457405	0.302317		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	BIO-MEDICAL (COST)	UTILITIES - HOSPITAL (SQUARE FEET)	UTILITIES - OFFSITE BLDGS (COST)	
			5.00	7.00	7.01	7.02	7.03	
		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
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,809,139					5.00
7.00	00700	OPERATION OF PLANT	1,945,734	109,034				7.00
7.01	00701	BIO-MEDICAL	123,073	436	13,550,856			7.01
7.02	00702	UTILITIES - HOSPITAL	784,397	0	0	85,778		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	89,621	0	0	0	89,620	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	229,172	1,729	0	1,729	0	8.00
9.00	00900	HOUSEKEEPING	627,156	2,753	0	2,354	0	9.00
10.00	01000	DIETARY	340,037	700	0	700	0	10.00
11.00	01100	CAFETERIA	818,465	6,254	0	6,254	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,150,077	587	0	587	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,005,592	1,585	0	1,585	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	790,221	2,539	0	2,539	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,051,518	19,453	2,377,225	19,453	0	30.00
31.00	03100	INTENSIVE CARE UNIT	854,185	3,224	52,813	3,224	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,119,419	7,149	4,306	7,149	0	40.00
43.00	04300	NURSERY	253,323	250	17,701	250	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,316,057	10,965	3,492,585	10,965	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	140,268	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,173,226	8,855	5,595,678	8,855	0	54.00
60.00	06000	LABORATORY	3,054,480	3,926	633,814	3,212	0	60.00
65.00	06500	RESPIRATORY THERAPY	897,246	4,089	701,224	4,089	0	65.00
66.00	06600	PHYSICAL THERAPY	943,198	3,475	262,604	3,475	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	246,928	100	0	100	0	67.00
68.00	06800	SPEECH PATHOLOGY	167,279	50	0	50	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,240,076	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	641,962	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,463,489	0	0	0	0	73.00
76.00	03020	OP PSYCH	301,190	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	503,907	4,386	5,551	0	0	90.00
90.01	09001	CLINIC - AMO	472,768	1,955	0	0	316	90.01
90.02	09002	CLINIC - AMH NEURO	42,691	0	24,274	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	544,783	2,325	49,167	0	0	90.03
91.00	09100	EMERGENCY	1,668,277	5,407	75,754	5,407	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,546,160	4,323	229,064	0	8,345	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,545,975	96,515	13,521,760	81,977	8,661	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,106	654	0	654	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	1,129,813	6,951	29,096	3,147	640	194.01
194.02	07952	OTHER MOBS	597,571	3,200	0	0	80,319	194.02
194.03	07953	MONROE	521,674	1,714	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,568,817	2,381,324	160,147	959,999	109,684	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.223869	21.840197	0.011818	11.191669	1.223879	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	387,951	412,299	12,465	9,001	1,028	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011475	3.781380	0.000920	0.104934	0.011471	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
			8.00	9.00	10.00	11.00	13.00	
		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
2.01	00201	OTHER CAP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	BIO-MEDICAL						7.01
7.02	00702	UTILITIES - HOSPITAL						7.02
7.03	00703	UTILITIES - OFFSITE BLDGS						7.03
8.00	00800	LAUNDRY & LINEN SERVICE	224,462					8.00
9.00	00900	HOUSEKEEPING	41,474	104,116				9.00
10.00	01000	DIETARY	2,227	700	23,094			10.00
11.00	01100	CAFETERIA	7,565	6,254	0	526,669		11.00
13.00	01300	NURSING ADMINISTRATION	0	587	0	23,999	199,610	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,585	0	14,574	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,539	0	16,406	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,703	19,453	15,015	77,550	77,550	30.00
31.00	03100	INTENSIVE CARE UNIT	8,379	3,224	2,508	19,568	19,568	31.00
40.00	04000	SUBPROVIDER - IPF	6,763	7,149	5,571	29,583	29,583	40.00
43.00	04300	NURSERY	0	250	0	5,647	5,647	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,832	10,965	0	38,362	38,362	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,175	0	0	3,195	3,195	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,068	8,855	0	34,055	0	54.00
60.00	06000	LABORATORY	121	3,926	0	44,918	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,955	4,089	0	24,481	0	65.00
66.00	06600	PHYSICAL THERAPY	12,104	3,475	0	30,897	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	100	0	14,825	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	50	0	4,303	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03020	OP PSYCH	1,803	0	0	7,887	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,207	4,386	0	18,549	0	90.00
90.01	09001	CLINIC - AMO	39	1,955	0	11,436	0	90.01
90.02	09002	CLINIC - AMH NEURO	10	0	0	1,084	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	544	2,325	0	10,124	0	90.03
91.00	09100	EMERGENCY	27,595	5,407	0	25,705	25,705	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,685	4,323	0	51,012	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	223,249	91,597	23,094	508,160	199,610	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	654	0	0	0	190.00
194.00	07950	TITLE XX	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	744	6,951	0	18,509	0	194.01
194.02	07952	OTHER MOBS	34	3,200	0	0	0	194.02
194.03	07953	MONROE	435	1,714	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	337,589	916,406	448,793	1,274,700	1,490,186	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.503992	8.801779	19.433316	2.420306	7.465488	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,643	77,430	22,705	174,816	36,543	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.207799	0.743690	0.983156	0.331928	0.183072	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 7:55 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	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
2.01	00201	OTHER CAP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	BIO-MEDICAL					7.01
7.02	00702	UTILITIES - HOSPITAL					7.02
7.03	00703	UTILITIES - OFFSITE BLDGS					7.03
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	0				14.00
15.00	01500	PHARMACY	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,577,770		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	524,089		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	50,401		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	104,537		40.00
43.00	04300	NURSERY	0	0	3,482		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	142,682		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	17,145		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	13,332		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
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	100	0		73.00
76.00	03020	OP PSYCH	0	0	27,871		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	5,671		90.00
90.01	09001	CLINIC - AMO	0	0	9,885		90.01
90.02	09002	CLINIC - AMH NEURO	0	0	2,200		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	8,831		90.03
91.00	09100	EMERGENCY	0	0	651,071		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	100	1,561,197		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	TITLE XX	0	0	0		194.00
194.01	07951	OTHER NRCC	0	0	12,173		194.01
194.02	07952	OTHER MOBS	0	0	1,394		194.02
194.03	07953	MONROE	0	0	3,006		194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,332,294	1,113,051		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	13,322.940000	0.705458		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	57,903	81,034		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	579.030000	0.051360		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,061,400		6,061,400	0	6,061,400	30.00
31.00	03100	INTENSIVE CARE UNIT	1,471,250		1,471,250	0	1,471,250	31.00
40.00	04000	SUBPROVIDER - IPF	2,153,774		2,153,774	0	2,153,774	40.00
43.00	04300	NURSERY	378,982		378,982	0	378,982	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,868,318		3,868,318	0	3,868,318	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	211,038		211,038	0	211,038	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,219,512		3,219,512	0	3,219,512	54.00
60.00	06000	LABORATORY	4,010,915		4,010,915	0	4,010,915	60.00
65.00	06500	RESPIRATORY THERAPY	1,355,070	0	1,355,070	0	1,355,070	65.00
66.00	06600	PHYSICAL THERAPY	1,395,810	0	1,395,810	0	1,395,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,272	0	342,272	0	342,272	67.00
68.00	06800	SPEECH PATHOLOGY	217,235	0	217,235	0	217,235	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,517,691		1,517,691	0	1,517,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	785,677		785,677	0	785,677	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,123,413		3,123,413	0	3,123,413	73.00
76.00	03020	OP PSYCH	410,080		410,080	0	410,080	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	801,888		801,888	0	801,888	90.00
90.01	09001	CLINIC - AMO	673,609		673,609	0	673,609	90.01
90.02	09002	CLINIC - AMH NEURO	56,726		56,726	0	56,726	90.02
90.03	09003	CLINIC - NIGLIAZZO	770,117		770,117	0	770,117	90.03
91.00	09100	EMERGENCY	3,023,763		3,023,763	0	3,023,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	938,277		938,277		938,277	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,175,713		2,175,713	0	2,175,713	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	38,962,530	0	38,962,530	0	38,962,530	200.00
201.00		Less Observation Beds	938,277		938,277		938,277	201.00
202.00		Total (see instructions)	38,024,253	0	38,024,253	0	38,024,253	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,603,407		5,603,407			30.00
31.00	03100	INTENSIVE CARE UNIT	1,749,495		1,749,495			31.00
40.00	04000	SUBPROVIDER - IPF	2,541,749		2,541,749			40.00
43.00	04300	NURSERY	254,849		254,849			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,268,638	5,803,834	8,072,472	0.479199	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,183	72,111	216,294	0.975700	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,940,126	15,999,511	17,939,637	0.179464	0.000000	54.00
60.00	06000	LABORATORY	3,338,588	13,632,363	16,970,951	0.236340	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,444,758	2,465,074	5,909,832	0.229291	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	295,171	2,106,142	2,401,313	0.581269	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,683	258,658	389,341	0.879106	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	84,348	257,535	341,883	0.635407	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,777,404	813,492	2,590,896	0.585778	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,414,339	233,951	1,648,290	0.476662	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,537,583	4,632,444	9,170,027	0.340611	0.000000	73.00
76.00	03020	OP PSYCH	0	677,664	677,664	0.605138	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,761,711	1,761,711	0.455176	0.000000	90.00
90.01	09001	CLINIC - AMO	0	3,050,357	3,050,357	0.220830	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	680,468	680,468	0.083363	0.000000	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,734,576	2,734,576	0.281622	0.000000	90.03
91.00	09100	EMERGENCY	299,470	2,640,940	2,940,410	1.028347	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,458,144	1,458,144	0.643473	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,894,796	2,894,796	0.751595	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	29,824,791	62,173,771	91,998,562			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,824,791	62,173,771	91,998,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.479199		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464		54.00
60.00	06000	LABORATORY	0.236340		60.00
65.00	06500	RESPIRATORY THERAPY	0.229291		65.00
66.00	06600	PHYSICAL THERAPY	0.581269		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106		67.00
68.00	06800	SPEECH PATHOLOGY	0.635407		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611		73.00
76.00	03020	OP PSYCH	0.605138		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.455176		90.00
90.01	09001	CLINIC - AMO	0.220830		90.01
90.02	09002	CLINIC - AMH NEURO	0.083363		90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622		90.03
91.00	09100	EMERGENCY	1.028347		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.751595		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,061,400		6,061,400	0	6,061,400	30.00
31.00	03100	INTENSIVE CARE UNIT	1,471,250		1,471,250	0	1,471,250	31.00
40.00	04000	SUBPROVIDER - IPF	2,153,774		2,153,774	0	2,153,774	40.00
43.00	04300	NURSERY	378,982		378,982	0	378,982	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,868,318		3,868,318	0	3,868,318	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	211,038		211,038	0	211,038	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,219,512		3,219,512	0	3,219,512	54.00
60.00	06000	LABORATORY	4,010,915		4,010,915	0	4,010,915	60.00
65.00	06500	RESPIRATORY THERAPY	1,355,070	0	1,355,070	0	1,355,070	65.00
66.00	06600	PHYSICAL THERAPY	1,395,810	0	1,395,810	0	1,395,810	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,272	0	342,272	0	342,272	67.00
68.00	06800	SPEECH PATHOLOGY	217,235	0	217,235	0	217,235	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,517,691		1,517,691	0	1,517,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	785,677		785,677	0	785,677	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,123,413		3,123,413	0	3,123,413	73.00
76.00	03020	OP PSYCH	410,080		410,080	0	410,080	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	801,888		801,888	0	801,888	90.00
90.01	09001	CLINIC - AMO	673,609		673,609	0	673,609	90.01
90.02	09002	CLINIC - AMH NEURO	56,726		56,726	0	56,726	90.02
90.03	09003	CLINIC - NIGLIAZZO	770,117		770,117	0	770,117	90.03
91.00	09100	EMERGENCY	3,023,763		3,023,763	0	3,023,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	938,277		938,277		938,277	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,175,713		2,175,713	0	2,175,713	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	38,962,530	0	38,962,530	0	38,962,530	200.00
201.00		Less Observation Beds	938,277		938,277		938,277	201.00
202.00		Total (see instructions)	38,024,253	0	38,024,253	0	38,024,253	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,603,407		5,603,407			30.00
31.00	03100	INTENSIVE CARE UNIT	1,749,495		1,749,495			31.00
40.00	04000	SUBPROVIDER - IPF	2,541,749		2,541,749			40.00
43.00	04300	NURSERY	254,849		254,849			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,268,638	5,803,834	8,072,472	0.479199	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,183	72,111	216,294	0.975700	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,940,126	15,999,511	17,939,637	0.179464	0.000000	54.00
60.00	06000	LABORATORY	3,338,588	13,632,363	16,970,951	0.236340	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,444,758	2,465,074	5,909,832	0.229291	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	295,171	2,106,142	2,401,313	0.581269	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,683	258,658	389,341	0.879106	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	84,348	257,535	341,883	0.635407	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,777,404	813,492	2,590,896	0.585778	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,414,339	233,951	1,648,290	0.476662	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,537,583	4,632,444	9,170,027	0.340611	0.000000	73.00
76.00	03020	OP PSYCH	0	677,664	677,664	0.605138	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,761,711	1,761,711	0.455176	0.000000	90.00
90.01	09001	CLINIC - AMO	0	3,050,357	3,050,357	0.220830	0.000000	90.01
90.02	09002	CLINIC - AMH NEURO	0	680,468	680,468	0.083363	0.000000	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,734,576	2,734,576	0.281622	0.000000	90.03
91.00	09100	EMERGENCY	299,470	2,640,940	2,940,410	1.028347	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,458,144	1,458,144	0.643473	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,894,796	2,894,796	0.751595	0.000000	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	29,824,791	62,173,771	91,998,562			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	29,824,791	62,173,771	91,998,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.479199		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464		54.00
60.00	06000	LABORATORY	0.236340		60.00
65.00	06500	RESPIRATORY THERAPY	0.229291		65.00
66.00	06600	PHYSICAL THERAPY	0.581269		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106		67.00
68.00	06800	SPEECH PATHOLOGY	0.635407		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611		73.00
76.00	03020	OP PSYCH	0.605138		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.455176		90.00
90.01	09001	CLINIC - AMO	0.220830		90.01
90.02	09002	CLINIC - AMH NEURO	0.083363		90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622		90.03
91.00	09100	EMERGENCY	1.028347		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.751595		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

		Cost Center Description	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	3,868,318	351,599	3,516,719	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	211,038	4,331	206,707	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,219,512	278,227	2,941,285	0	0	54.00
60.00	06000	LABORATORY	4,010,915	138,270	3,872,645	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,355,070	128,119	1,226,951	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,395,810	114,879	1,280,931	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	342,272	10,373	331,899	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	217,235	4,658	212,577	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,517,691	14,230	1,503,461	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	785,677	7,367	778,310	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,123,413	74,697	3,048,716	0	0	73.00
76.00	03020	OP PSYCH	410,080	7,880	402,200	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	801,888	34,339	767,549	0	0	90.00
90.01	09001	CLINIC - AMO	673,609	19,482	654,127	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	56,726	987	55,739	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	770,117	21,807	748,310	0	0	90.03
91.00	09100	EMERGENCY	3,023,763	213,283	2,810,480	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	938,277	99,193	839,084	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,175,713	58,533	2,117,180	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	28,897,124	1,582,254	27,314,870	0	0	200.00
201.00		Less Observation Beds	938,277	99,193	839,084	0	0	201.00
202.00		Total (line 200 minus line 201)	27,958,847	1,483,061	26,475,786	0	0	202.00

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

Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prepared: 5/28/2015 7:55 am

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	3,868,318	8,072,472	0.479199		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	211,038	216,294	0.975700		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,219,512	17,939,637	0.179464		54.00
60.00	06000	LABORATORY	4,010,915	16,970,951	0.236340		60.00
65.00	06500	RESPIRATORY THERAPY	1,355,070	5,909,832	0.229291		65.00
66.00	06600	PHYSICAL THERAPY	1,395,810	2,401,313	0.581269		66.00
67.00	06700	OCCUPATIONAL THERAPY	342,272	389,341	0.879106		67.00
68.00	06800	SPEECH PATHOLOGY	217,235	341,883	0.635407		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,517,691	2,590,896	0.585778		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	785,677	1,648,290	0.476662		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,123,413	9,170,027	0.340611		73.00
76.00	03020	OP PSYCH	410,080	677,664	0.605138		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	801,888	1,761,711	0.455176		90.00
90.01	09001	CLINIC - AMO	673,609	3,050,357	0.220830		90.01
90.02	09002	CLINIC - AMH NEURO	56,726	680,468	0.083363		90.02
90.03	09003	CLINIC - NIGLIAZZO	770,117	2,734,576	0.281622		90.03
91.00	09100	EMERGENCY	3,023,763	2,940,410	1.028347		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	938,277	1,458,144	0.643473		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,175,713	2,894,796	0.751595		95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000		97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	28,897,124	81,849,062			200.00
201.00		Less Observation Beds	938,277	0			201.00
202.00		Total (line 200 minus line 201)	27,958,847	81,849,062			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		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	351,599	8,072,472	0.043555	235,386	10,252	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,331	216,294	0.020024	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	278,227	17,939,637	0.015509	611,591	9,485	54.00
60.00	06000	LABORATORY	138,270	16,970,951	0.008147	1,457,900	11,878	60.00
65.00	06500	RESPIRATORY THERAPY	128,119	5,909,832	0.021679	1,480,736	32,101	65.00
66.00	06600	PHYSICAL THERAPY	114,879	2,401,313	0.047840	147,269	7,045	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,373	389,341	0.026642	62,540	1,666	67.00
68.00	06800	SPEECH PATHOLOGY	4,658	341,883	0.013625	50,183	684	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,230	2,590,896	0.005492	1,658,093	9,106	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,367	1,648,290	0.004469	233	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,697	9,170,027	0.008146	1,783,807	14,531	73.00
76.00	03020	OP PSYCH	7,880	677,664	0.011628	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,339	1,761,711	0.019492	0	0	90.00
90.01	09001	CLINIC - AMO	19,482	3,050,357	0.006387	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	987	680,468	0.001450	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	21,807	2,734,576	0.007975	0	0	90.03
91.00	09100	EMERGENCY	213,283	2,940,410	0.072535	4,055	294	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	99,193	1,458,144	0.068027	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,523,721	78,954,266		7,491,793	97,043	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		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	8,072,472	0.000000	0.000000	235,386	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	216,294	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,939,637	0.000000	0.000000	611,591	54.00
60.00	06000	LABORATORY	0	16,970,951	0.000000	0.000000	1,457,900	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,909,832	0.000000	0.000000	1,480,736	65.00
66.00	06600	PHYSICAL THERAPY	0	2,401,313	0.000000	0.000000	147,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	389,341	0.000000	0.000000	62,540	67.00
68.00	06800	SPEECH PATHOLOGY	0	341,883	0.000000	0.000000	50,183	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,590,896	0.000000	0.000000	1,658,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,648,290	0.000000	0.000000	233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,170,027	0.000000	0.000000	1,783,807	73.00
76.00	03020	OP PSYCH	0	677,664	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,761,711	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,050,357	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	680,468	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,734,576	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	2,940,410	0.000000	0.000000	4,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,458,144	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	78,954,266			7,491,793	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.479199	0	1,283,623	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700	0	994	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464	0	3,360,460	0	0	54.00
60.00	06000	LABORATORY	0.236340	0	1,603,653	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.229291	0	1,243,589	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.581269	0	539,449	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106	0	29,929	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.635407	0	14,186	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778	0	617,476	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662	0	54,984	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611	0	1,333,060	1,397	0	73.00
76.00	03020	OP PSYCH	0.605138	0	68,620	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.455176	0	0	720	0	90.00
90.01	09001	CLINIC - AMO	0.220830	0	209,082	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.083363	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622	0	0	0	0	90.03
91.00	09100	EMERGENCY	1.028347	0	600,037	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473	0	246,618	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.751595		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		0	11,205,760	2,117	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	11,205,760	2,117	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	615,111	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	970	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	603,082	0		54.00
60.00	06000	LABORATORY	379,007	0		60.00
65.00	06500	RESPIRATORY THERAPY	285,144	0		65.00
66.00	06600	PHYSICAL THERAPY	313,565	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	26,311	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,014	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	361,704	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,209	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	454,055	476		73.00
76.00	03020	OP PSYCH	41,525	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	328		90.00
90.01	09001	CLINIC - AMO	46,172	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
91.00	09100	EMERGENCY	617,046	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	158,692	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	3,937,607	804		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,937,607	804		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Subprovider - IPF | 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	351,599	8,072,472	0.043555	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,331	216,294	0.020024	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	278,227	17,939,637	0.015509	20,484	318	54.00
60.00	06000	LABORATORY	138,270	16,970,951	0.008147	80,655	657	60.00
65.00	06500	RESPIRATORY THERAPY	128,119	5,909,832	0.021679	31,486	683	65.00
66.00	06600	PHYSICAL THERAPY	114,879	2,401,313	0.047840	399	19	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,373	389,341	0.026642	719	19	67.00
68.00	06800	SPEECH PATHOLOGY	4,658	341,883	0.013625	359	5	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,230	2,590,896	0.005492	20,830	114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,367	1,648,290	0.004469	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,697	9,170,027	0.008146	132,680	1,081	73.00
76.00	03020	OP PSYCH	7,880	677,664	0.011628	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,339	1,761,711	0.019492	0	0	90.00
90.01	09001	CLINIC - AMO	19,482	3,050,357	0.006387	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	987	680,468	0.001450	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	21,807	2,734,576	0.007975	0	0	90.03
91.00	09100	EMERGENCY	213,283	2,940,410	0.072535	175	13	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,458,144	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,424,528	78,954,266		287,787	2,909	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Subprovider - IPF | PPS

		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	8,072,472	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	216,294	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,939,637	0.000000	0.000000	20,484	54.00
60.00	06000	LABORATORY	0	16,970,951	0.000000	0.000000	80,655	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,909,832	0.000000	0.000000	31,486	65.00
66.00	06600	PHYSICAL THERAPY	0	2,401,313	0.000000	0.000000	399	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	389,341	0.000000	0.000000	719	67.00
68.00	06800	SPEECH PATHOLOGY	0	341,883	0.000000	0.000000	359	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,590,896	0.000000	0.000000	20,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,648,290	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,170,027	0.000000	0.000000	132,680	73.00
76.00	03020	OP PSYCH	0	677,664	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,761,711	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,050,357	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	680,468	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,734,576	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	2,940,410	0.000000	0.000000	175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,458,144	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	78,954,266			287,787	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Subprovider - IPF | 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151330 | Component CCN: 15Z330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.479199	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464	0	0	0	0	54.00
60.00	06000	LABORATORY	0.236340	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.229291	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.581269	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.635407	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611	0	0	0	0	73.00
76.00	03020	OP PSYCH	0.605138	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.455176	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0.220830	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.083363	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622	0	0	0	0	90.03
91.00	09100	EMERGENCY	1.028347	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.751595		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151330 | Component CCN: 15Z330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	636,315	0	636,315	5,690	111.83	30.00
31.00	INTENSIVE CARE UNIT	111,192		111,192	836	133.00	31.00
40.00	SUBPROVIDER - IPF	227,636	0	227,636	1,857	122.58	40.00
43.00	NURSERY	12,559		12,559	403	31.16	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	987,702		987,702	8,786		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	244	27,287	30.00
31.00	INTENSIVE CARE UNIT	31	4,123	31.00
40.00	SUBPROVIDER - IPF	290	35,548	40.00
43.00	NURSERY	21	654	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	586	67,612	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/28/2015 7:55 am

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	351,599	8,072,472	0.043555	70,296	3,062	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,331	216,294	0.020024	32,187	645	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	278,227	17,939,637	0.015509	60,698	941	54.00
60.00	06000	LABORATORY	138,270	16,970,951	0.008147	154,093	1,255	60.00
65.00	06500	RESPIRATORY THERAPY	128,119	5,909,832	0.021679	109,449	2,373	65.00
66.00	06600	PHYSICAL THERAPY	114,879	2,401,313	0.047840	2,215	106	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,373	389,341	0.026642	539	14	67.00
68.00	06800	SPEECH PATHOLOGY	4,658	341,883	0.013625	547	7	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,230	2,590,896	0.005492	86,303	474	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,367	1,648,290	0.004469	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,697	9,170,027	0.008146	239,451	1,951	73.00
76.00	03020	OP PSYCH	7,880	677,664	0.011628	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,339	1,761,711	0.019492	0	0	90.00
90.01	09001	CLINIC - AMO	19,482	3,050,357	0.006387	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	987	680,468	0.001450	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	21,807	2,734,576	0.007975	0	0	90.03
91.00	09100	EMERGENCY	213,283	2,940,410	0.072535	49,504	3,591	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	99,193	1,458,144	0.068027	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,523,721	78,954,266		805,282	14,419	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/28/2015 7:55 am

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
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	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)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,690	0.00	244	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	836	0.00	31	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,857	0.00	290	0	0	40.00
43.00	04300	NURSERY	403	0.00	21	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
200.00		Total (lines 30-199)	8,786		586	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

		Cost Center Description	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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

		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	8,072,472	0.000000	0.000000	70,296	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	216,294	0.000000	0.000000	32,187	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,939,637	0.000000	0.000000	60,698	54.00
60.00	06000	LABORATORY	0	16,970,951	0.000000	0.000000	154,093	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,909,832	0.000000	0.000000	109,449	65.00
66.00	06600	PHYSICAL THERAPY	0	2,401,313	0.000000	0.000000	2,215	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	389,341	0.000000	0.000000	539	67.00
68.00	06800	SPEECH PATHOLOGY	0	341,883	0.000000	0.000000	547	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,590,896	0.000000	0.000000	86,303	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,648,290	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,170,027	0.000000	0.000000	239,451	73.00
76.00	03020	OP PSYCH	0	677,664	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,761,711	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,050,357	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	680,468	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,734,576	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	2,940,410	0.000000	0.000000	49,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,458,144	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	78,954,266			805,282	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Subprovider - IPF | 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	351,599	8,072,472	0.043555	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,331	216,294	0.020024	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	278,227	17,939,637	0.015509	664	10	54.00
60.00	06000	LABORATORY	138,270	16,970,951	0.008147	26,382	215	60.00
65.00	06500	RESPIRATORY THERAPY	128,119	5,909,832	0.021679	7,127	155	65.00
66.00	06600	PHYSICAL THERAPY	114,879	2,401,313	0.047840	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,373	389,341	0.026642	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,658	341,883	0.013625	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,230	2,590,896	0.005492	1,880	10	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,367	1,648,290	0.004469	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,697	9,170,027	0.008146	43,550	355	73.00
76.00	03020	OP PSYCH	7,880	677,664	0.011628	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	34,339	1,761,711	0.019492	0	0	90.00
90.01	09001	CLINIC - AMO	19,482	3,050,357	0.006387	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	987	680,468	0.001450	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	21,807	2,734,576	0.007975	0	0	90.03
91.00	09100	EMERGENCY	213,283	2,940,410	0.072535	253	18	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,458,144	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,424,528	78,954,266		79,856	763	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Subprovider - IPF | PPS

		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	8,072,472	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	216,294	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,939,637	0.000000	0.000000	664	54.00
60.00	06000	LABORATORY	0	16,970,951	0.000000	0.000000	26,382	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,909,832	0.000000	0.000000	7,127	65.00
66.00	06600	PHYSICAL THERAPY	0	2,401,313	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	389,341	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	341,883	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,590,896	0.000000	0.000000	1,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,648,290	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,170,027	0.000000	0.000000	43,550	73.00
76.00	03020	OP PSYCH	0	677,664	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,761,711	0.000000	0.000000	0	90.00
90.01	09001	CLINIC - AMO	0	3,050,357	0.000000	0.000000	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	680,468	0.000000	0.000000	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	2,734,576	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	2,940,410	0.000000	0.000000	253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,458,144	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	78,954,266			79,856	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Subprovider - IPF | 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
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
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0	0	0	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC - AMO	0	0		90.01
90.02	09002	CLINIC - AMH NEURO	0	0		90.02
90.03	09003	CLINIC - NIGLIAZZO	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,846	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,690	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)	4,803	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	24	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	132	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)	2,334	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)	24	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	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)	6,061,400	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)	17,046	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)	42,433	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,018,967	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)	6,018,967	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)	1,057.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,468,929	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)	2,468,929	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,471,250	836	1,759.87	377	663,471	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,662,243	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,794,643	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	25,387	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)	25,387	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)	887	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,057.81	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	938,277	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

	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	636,315	6,018,967	0.105718	938,277	99,193	90.00
91.00	Nursing School cost	0	6,018,967	0.000000	938,277	0	91.00
92.00	Allied health cost	0	6,018,967	0.000000	938,277	0	92.00
93.00	All other Medical Education	0	6,018,967	0.000000	938,277	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/28/2015 7:55 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,857	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,857	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)	1,857	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)	600	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	2,153,774	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)	2,153,774	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)	2,153,774	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)	1,159.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	695,886	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)	695,886	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	88,623	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	784,509	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,909	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,909	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	781,600	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/28/2015 7:55 am
	Title XVIII	Subprovider - IPF	PPS

	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	0	2,153,774	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,153,774	0.000000	0	0	91.00
92.00	Allied health cost	0	2,153,774	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,153,774	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,846	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,690	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)	4,803	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	132	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)	244	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)	403	15.00
16.00	Nursery days (title V or XIX only)	21	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	6,061,400	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)	6,061,400	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)	6,061,400	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)	1,065.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	259,926	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)	259,926	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 7:55 am

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	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)	378,982	403	940.40	21	19,748	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,471,250	836	1,759.87	31	54,556	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	322,629	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	656,859	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)	32,064	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,419	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	46,483	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	610,376	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)	887	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,065.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	944,894	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

	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	636,315	6,061,400	0.104978	944,894	99,193	90.00
91.00	Nursing School cost	0	6,061,400	0.000000	944,894	0	91.00
92.00	Allied health cost	0	6,061,400	0.000000	944,894	0	92.00
93.00	All other Medical Education	0	6,061,400	0.000000	944,894	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/28/2015 7:55 am
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,857	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,857	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)	1,857	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)	290	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)	403	15.00
16.00	Nursery days (title V or XIX only)	21	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	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)	2,153,774	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)	2,153,774	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)	2,153,774	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)	1,159.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	336,345	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)	336,345	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	24,183	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	360,528	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)	35,548	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	763	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	36,311	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	324,217	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/28/2015 7:55 am
	Title XIX	Subprovider - IPF	PPS

	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	227,636	2,153,774	0.105692	0	0	90.00
91.00	Nursing School cost	0	2,153,774	0.000000	0	0	91.00
92.00	Allied health cost	0	2,153,774	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,153,774	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		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		2,556,499		30.00
31.00	03100	INTENSIVE CARE UNIT		821,860		31.00
40.00	04000	SUBPROVIDER - IPF		30,767		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.479199	235,386	112,797	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464	611,591	109,759	54.00
60.00	06000	LABORATORY	0.236340	1,457,900	344,560	60.00
65.00	06500	RESPIRATORY THERAPY	0.229291	1,480,736	339,519	65.00
66.00	06600	PHYSICAL THERAPY	0.581269	147,269	85,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106	62,540	54,979	67.00
68.00	06800	SPEECH PATHOLOGY	0.635407	50,183	31,887	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778	1,658,093	971,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662	233	111	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611	1,783,807	607,584	73.00
76.00	03020	OP PSYCH	0.605138	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.455176	0	0	90.00
90.01	09001	CLINIC - AMO	0.220830	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.083363	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622	0	0	90.03
91.00	09100	EMERGENCY	1.028347	4,055	4,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		7,491,793	2,662,243	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)		7,491,793		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Subprovider - IPF | PPS

		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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		751,252		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.479199	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464	20,484	3,676	54.00
60.00	06000	LABORATORY	0.236340	80,655	19,062	60.00
65.00	06500	RESPIRATORY THERAPY	0.229291	31,486	7,219	65.00
66.00	06600	PHYSICAL THERAPY	0.581269	399	232	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106	719	632	67.00
68.00	06800	SPEECH PATHOLOGY	0.635407	359	228	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778	20,830	12,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611	132,680	45,192	73.00
76.00	03020	OP PSYCH	0.605138	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.455176	0	0	90.00
90.01	09001	CLINIC - AMO	0.220830	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.083363	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622	0	0	90.03
91.00	09100	EMERGENCY	1.028347	175	180	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		287,787	88,623	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)		287,787		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151330 | Component CCN: 15Z330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Swing Beds - SNF | Cost

		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		15,768		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.479199	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464	528	95	54.00
60.00	06000	LABORATORY	0.236340	3,468	820	60.00
65.00	06500	RESPIRATORY THERAPY	0.229291	10,327	2,368	65.00
66.00	06600	PHYSICAL THERAPY	0.581269	2,406	1,399	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106	2,427	2,134	67.00
68.00	06800	SPEECH PATHOLOGY	0.635407	1,660	1,055	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778	10,298	6,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611	11,698	3,984	73.00
76.00	03020	OP PSYCH	0.605138	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.455176	0	0	90.00
90.01	09001	CLINIC - AMO	0.220830	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.083363	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622	0	0	90.03
91.00	09100	EMERGENCY	1.028347	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		42,812	17,887	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)		42,812		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Hospital | PPS

		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		280,275		30.00
31.00	03100	INTENSIVE CARE UNIT		69,760		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		7,942		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.479199	70,296	33,686	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700	32,187	31,405	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464	60,698	10,893	54.00
60.00	06000	LABORATORY	0.236340	154,093	36,418	60.00
65.00	06500	RESPIRATORY THERAPY	0.229291	109,449	25,096	65.00
66.00	06600	PHYSICAL THERAPY	0.581269	2,215	1,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106	539	474	67.00
68.00	06800	SPEECH PATHOLOGY	0.635407	547	348	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778	86,303	50,554	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611	239,451	81,560	73.00
76.00	03020	OP PSYCH	0.605138	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.455176	0	0	90.00
90.01	09001	CLINIC - AMO	0.220830	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.083363	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622	0	0	90.03
91.00	09100	EMERGENCY	1.028347	49,504	50,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		805,282	322,629	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)		805,282		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Subprovider - IPF | PPS

		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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		347,823		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.479199	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464	664	119	54.00
60.00	06000	LABORATORY	0.236340	26,382	6,235	60.00
65.00	06500	RESPIRATORY THERAPY	0.229291	7,127	1,634	65.00
66.00	06600	PHYSICAL THERAPY	0.581269	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.635407	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778	1,880	1,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611	43,550	14,834	73.00
76.00	03020	OP PSYCH	0.605138	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.455176	0	0	90.00
90.01	09001	CLINIC - AMO	0.220830	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.083363	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622	0	0	90.03
91.00	09100	EMERGENCY	1.028347	253	260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		79,856	24,183	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)		79,856		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151330 | Component CCN: 15Z330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 7:55 am

Title XIX | Swing Beds - SNF | PPS

		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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.479199	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.975700	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179464	0	0	54.00
60.00	06000	LABORATORY	0.236340	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.229291	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.581269	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.879106	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.635407	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.585778	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.476662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340611	0	0	73.00
76.00	03020	OP PSYCH	0.605138	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.455176	0	0	90.00
90.01	09001	CLINIC - AMO	0.220830	0	0	90.01
90.02	09002	CLINIC - AMH NEURO	0.083363	0	0	90.02
90.03	09003	CLINIC - NIGLIAZZO	0.281622	0	0	90.03
91.00	09100	EMERGENCY	1.028347	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.643473	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151330	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 7:55 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,938,411	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,938,411	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,977,795	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	45,113	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,934,513	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)	1,998,169	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,998,169	30.00
31.00	Primary payer payments	735	31.00
32.00	Subtotal (line 30 minus line 31)	1,997,434	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)	67,557	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	51,343	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	67,557	36.00
37.00	Subtotal (see instructions)	2,048,777	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,048,777	40.00
40.01	Sequestration adjustment (see instructions)	40,976	40.01
41.00	Interim payments	2,386,823	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-379,022	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

		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,909,801		2,386,823	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	08/12/2014	170,000		0	3.01
3.02		11/26/2014	96,500		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)		266,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,176,301		2,386,823	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		115,084		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		379,022	6.02
7.00	Total Medicare program liability (see instructions)		5,291,385		2,007,801	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151330 | Component CCN: 15M330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Subprovider - IPF | 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		458,785		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		458,785		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		9		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		458,794		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151330 | Component CCN: 15Z330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2015 7:55 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		32,246		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		32,246		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		9,246		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		41,492		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151330	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/28/2015 7:55 am
	Title XVIII	Hospital	Cost

		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	1,512	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,711	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	893	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	5,639	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	91,998,562	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,737,735	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)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151330 Component CCN: 15Z330	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/28/2015 7:55 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	25,641	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	18,066	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	24	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	43,707	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	43,707	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	43,707	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,368	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	42,339	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	42,339	0	19.00
19.01	Sequestration adjustment (see instructions)	847	0	19.01
20.00	Interim payments	32,246	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	9,246	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151330 Component CCN: 15Z330	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/28/2015 7:55 am
	Title XIX	Swing Beds - SNF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151330	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/28/2015 7:55 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,794,643	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,794,643	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,852,589	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,852,589	19.00
20.00	Deductibles (exclude professional component)	472,768	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,379,821	22.00
23.00	Coinsurance	12,160	23.00
24.00	Subtotal (line 22 minus line 23)	5,367,661	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	41,725	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	31,711	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	41,725	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,399,372	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	5,399,372	30.00
30.01	Sequestration adjustment (see instructions)	107,987	30.01
31.00	Interim payments	5,176,301	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	115,084	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/28/2015 7:55 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	539,580	1.00
2.00	Net IPF PPS Outlier Payments	2,753	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	5.087671	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	542,333	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	542,333	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	542,333	18.00
19.00	Deductibles	74,176	19.00
20.00	Subtotal (line 18 minus line 19)	468,157	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	468,157	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	468,157	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	468,157	31.00
31.01	Sequestration adjustment (see instructions)	9,363	31.01
32.00	Interim payments	458,785	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	9	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	2,753	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-3 Part VII Date/Time Prepared: 5/28/2015 7:55 am

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		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	357,977		8.00
9.00	Ancillary service charges	805,282	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,163,259	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,163,259	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,163,259	0	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	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2015 7:55 am
	Title XIX	Subprovider - IPF	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		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	347,823		8.00
9.00	Ancillary service charges	79,856	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	427,679	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	427,679	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	427,679	0	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	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/28/2015 7:55 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,563,966	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	14,558,322	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	670,768	0	0	0	7.00
8.00	Prepaid expenses	113,805	0	0	0	8.00
9.00	Other current assets	127,049	0	0	0	9.00
10.00	Due from other funds	-2,737,629	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,296,281	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	359,555	0	0	0	12.00
13.00	Land improvements	1,558,293	0	0	0	13.00
14.00	Accumulated depreciation	-1,264,755	0	0	0	14.00
15.00	Buildings	38,118,083	0	0	0	15.00
16.00	Accumulated depreciation	-14,471,981	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	4,394,017	0	0	0	19.00
20.00	Accumulated depreciation	-2,095,170	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	21,555,348	0	0	0	23.00
24.00	Accumulated depreciation	-16,898,239	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)	31,255,151	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,468,738	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,468,738	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	52,020,170	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,633,334	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,907,604	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				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,407,402	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,948,340	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	32,870,912	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	32,870,912	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	41,819,252	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,200,918				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,200,918	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	52,020,170	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/28/2015 7:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,892,120		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		874,855				2.00
3.00	Total (sum of line 1 and line 2)		11,766,975		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)		11,766,975		0		11.00
12.00	CHANGE IN PY FUND BALANCES	1,566,057		0		0	12.00
13.00		0		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)		1,566,057		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,200,918		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	CHANGE IN PY FUND BALANCES		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/28/2015 7:55 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,002,049		6,002,049	1.00
2.00	SUBPROVIDER - IPF	2,541,749		2,541,749	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,543,798		8,543,798	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,749,495		1,749,495	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,749,495		1,749,495	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,293,293		10,293,293	17.00
18.00	Ancillary services	18,314,613	67,151,330	85,465,943	18.00
19.00	Outpatient services	0	2,364,834	2,364,834	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	28,607,906	69,516,164	98,124,070	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,160,403		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		47,160,403		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151330 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/28/2015 7:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	98,124,070	1.00
2.00	Less contractual allowances and discounts on patients' accounts	53,565,369	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,558,701	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	47,160,403	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,601,702	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,078,769	6.00
7.00	Income from investments	141,884	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	420,144	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	9,972	17.00
18.00	Revenue from sale of medical records and abstracts	24,583	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	241,405	22.00
23.00	Governmental appropriations	430,855	23.00
24.00	LIFELINE	20	24.00
24.01	JC BH MGT	31,250	24.01
24.02	MISC CASH	7,321	24.02
24.03	WORTHMAN FITNESS CENTER	79,428	24.03
24.04	CEDIT	1,250,263	24.04
24.05	GRANT	2,500	24.05
24.06	MISC	67,266	24.06
24.07		0	24.07
24.08		0	24.08
25.00	Total other income (sum of lines 6-24)	3,785,660	25.00
26.00	Total (line 5 plus line 25)	1,183,958	26.00
27.00	INSTITUTIONAL PHARMACY CLEARING	159,629	27.00
27.01	LOSS ON ASSET DISPOSAL	55,424	27.01
27.02	AECC	94,050	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	309,103	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	874,855	29.00