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: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/26/2015 4:22 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/26/2015 Time: 4:22 pm
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 CLARK MEMORIAL HOSPITAL (150009) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/26/2015 Time: 4:22 pm
fuzWvUVqu7dIezkdVABZZXX1o:Jys0
:OjV1OW7rGg6oSEh299BKQlQ:hn5:y
XjR61QmFUP0PktIq

PI: Date: 5/26/2015 Time: 4:22 pm
v2iVtq3vNUHk7tzdFmLFuRQ1Kz7yL0
Mb4QT08Ei1:d3p75cqASzMbpjC3jPp
V9Uk0D7:PA0OBypn

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

CFO
Title

5/27/15
Date

		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	663,848	95,908	-117,189	0	1.00
2.00	Subprovider - IPF	0	1,693	-1		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	665,541	95,907	-117,189	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: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2015 4:18 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1220 MISSOURI AVENUE	PO Box: 69			1.00
2.00	City: JEFFERSONVILLE	State: IN	Zip Code: 47130	County: CLARK	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	CLARK MEMORIAL HOSPITAL	150009	31140	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	BEHAVIORIAL MEDICINE UNIT	15S009	31140	4	01/01/1992	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	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.	Y	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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	4,102	1,224	283	312	3,115	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: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/26/2015 4:18 pm

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 4:18 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	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: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 4:18 pm

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

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

		1.00	2.00	3.00	
	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: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 4:18 pm

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 4:18 pm

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	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.	Y	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)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 4:18 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2014	12/31/2014	170.00

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/26/2015 4:18 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	05/05/2015	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.	Y		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/01/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

		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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD	BKD	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD,LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-581-0435	LVCOSTREPORTS@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/26/2015 4:18 pm

		Part B	
		Date	
		4.00	
	PS&R Data		
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/01/2015	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/26/2015 4:18 pm

	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	135	49,275	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		135	49,275	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	34	12,410	0.00	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)		169	61,685	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		189				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: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2015 4:18 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	17,125	3,104	38,407			1.00
2.00	HMO and other (see instructions)	5,049	4,934				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	17,125	3,104	38,407			7.00
8.00	INTENSIVE CARE UNIT	4,181	730	9,032			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		268	3,310			13.00
14.00	Total (see instructions)	21,306	4,102	50,749	2.24	1,130.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,097	0	2,678	0.00	14.51	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				2.24	1,145.24	27.00
28.00	Observation Bed Days		0	4,150			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/26/2015 4:18 pm

	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	4,437	1,108	11,914	1.00
2.00	HMO and other (see instructions)			1,026	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	4,437	1,108	11,914	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	190	0	256	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II | Date/Time Prepared: 5/26/2015 4:18 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	56,308,492	0	56,308,492	2,382,092.43	23.64	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		127,639	0	127,639	4,666.27	27.35	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,059,872	-98,748	961,124	43,743.34	21.97	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		139,608	0	139,608	4,914.27	28.41	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		12,683,808	0	12,683,808			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		229,487	0	229,487			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	378,057	0	378,057	14,059.25	26.89	26.00
27.00	Administrative & General	5.00	7,837,265	0	7,837,265	317,196.86	24.71	27.00
28.00	Administrative & General under contract (see inst.)		772,330	0	772,330	5,670.15	136.21	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,120,714	2,973	1,123,687	54,466.00	20.63	30.00
31.00	Laundry & Linen Service	8.00	126,562	0	126,562	10,080.50	12.56	31.00
32.00	Housekeeping	9.00	1,573,703	0	1,573,703	116,996.00	13.45	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,377,967	0	1,377,967	105,906.04	13.01	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	488,712	0	488,712	13,145.18	37.18	38.00
39.00	Central Services and Supply	14.00	368,038	0	368,038	21,871.85	16.83	39.00
40.00	Pharmacy	15.00	2,570,970	0	2,570,970	71,594.25	35.91	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II | Date/Time Prepared: 5/26/2015 4:18 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	1,424,181	0	1,424,181	71,979.75	19.79	41.00
42.00	Social Service	17.00	1,695,022	0	1,695,022	55,533.25	30.52	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/26/2015 4:18 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		56,953,183	0	56,953,183	2,383,096.31	23.90	1.00
2.00	Excluded area salaries (see instructions)		1,059,872	-98,748	961,124	43,743.34	21.97	2.00
3.00	Subtotal salaries (line 1 minus line 2)		55,893,311	98,748	55,992,059	2,339,352.97	23.93	3.00
4.00	Subtotal other wages & related costs (see inst.)		139,608	0	139,608	4,914.27	28.41	4.00
5.00	Subtotal wage-related costs (see inst.)		12,683,808	0	12,683,808	0.00	22.65	5.00
6.00	Total (sum of lines 3 thru 5)		68,716,727	98,748	68,815,475	2,344,267.24	29.35	6.00
7.00	Total overhead cost (see instructions)		19,733,521	2,973	19,736,494	858,499.08	22.99	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/26/2015 4:18 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,892,249	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	35,705	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6,416,846	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	192,409	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	15,410	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	83,816	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	45,274	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,171,351	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	39,381	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	140,375	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,032,816	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Prepared: 5/26/2015 4:18 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/26/2015 4:18 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.354425	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	38,670,297	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	47,477,494	6.00
7.00	Medicaid cost (line 1 times line 6)	16,827,211	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)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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	2,217,298	1,755,403	3,972,701	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	785,866	622,159	1,408,025	21.00
22.00	Partial payment by patients approved for charity care	7,529	3,855	11,384	22.00
23.00	Cost of charity care (line 21 minus line 22)	778,337	618,304	1,396,641	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)	30,894,000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	954,891	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	29,939,109	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	10,611,169	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	12,007,810	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,007,810	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		10,922,141	10,922,141	-5,141,884	5,780,257	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	7,688,962	7,688,962	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	378,057	13,166,684	13,544,741	-35,859	13,508,882	4.00
5.01	00540	NONPATIENT TELEPHONES	290,382	399,227	689,609	-37,991	651,618	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	612,767	731,228	1,343,995	26,369	1,370,364	5.02
5.03	00570	ADMITTING	1,197,605	189,863	1,387,468	-511	1,386,957	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	914,446	1,015,384	1,929,830	-4	1,929,826	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	4,822,065	30,869,544	35,691,609	3,520	35,695,129	5.05
7.00	00700	OPERATION OF PLANT	1,120,714	6,035,761	7,156,475	97,327	7,253,802	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	126,562	842,095	968,657	0	968,657	8.00
9.00	00900	HOUSEKEEPING	1,573,703	329,527	1,903,230	-7,026	1,896,204	9.00
10.00	01000	DIETARY	1,377,967	1,734,937	3,112,904	-14,414	3,098,490	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	488,712	39,161	527,873	-7,448	520,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	368,038	202,206	570,244	180	570,424	14.00
15.00	01500	PHARMACY	2,570,970	7,423,764	9,994,734	0	9,994,734	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,424,181	810,959	2,235,140	-127,824	2,107,316	16.00
17.00	01700	SOCIAL SERVICE	1,695,022	415,074	2,110,096	-58	2,110,038	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	127,639	127,639	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,728,820	1,073,697	11,802,517	-558,161	11,244,356	30.00
31.00	03100	INTENSIVE CARE UNIT	4,293,878	930,097	5,223,975	-697,958	4,526,017	31.00
40.00	04000	SUBPROVIDER - IPF	735,939	104,372	840,311	-119,320	720,991	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	750,040	101,628	851,668	-74,345	777,323	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,005,560	14,229,121	18,234,681	-10,853,613	7,381,068	50.00
51.00	05100	RECOVERY ROOM	900,647	226,303	1,126,950	-208,713	918,237	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,219,139	382,866	1,602,005	-253,809	1,348,196	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,119,052	3,559,285	7,678,337	-2,270,055	5,408,282	54.00
59.00	05900	CARDIAC CATHETERIZATION	955,791	2,743,651	3,699,442	-2,592,461	1,106,981	59.00
60.00	06000	LABORATORY	2,632,526	3,371,250	6,003,776	-15,237	5,988,539	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,051,429	1,051,429	-966,962	84,467	63.00
64.00	06400	INTRAVENOUS THERAPY	204,063	361,195	565,258	0	565,258	64.00
65.00	06500	RESPIRATORY THERAPY	1,654,745	1,077,264	2,732,009	-139,355	2,592,654	65.00
66.00	06600	PHYSICAL THERAPY	842,458	22,571	865,029	-12,852	852,177	66.00
69.00	06900	ELECTROCARDIOLOGY	541,227	63,187	604,414	-24,063	580,351	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	50,964	57,937	108,901	-509	108,392	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,767,923	10,767,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,850,930	8,850,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	404,335	404,335	0	404,335	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	123,741	11,884	135,625	0	135,625	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,264,778	1,373,298	4,638,076	-797,327	3,840,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,741,731	2,741,731	-2,562,920	178,811	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,984,559	109,014,656	164,999,215	42,171	165,041,386	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	SIRH	256,424	49,916	306,340	-39,021	267,319	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	67,509	700,190	767,699	-3,150	764,549	194.01
200.00		TOTAL (SUM OF LINES 118-199)	56,308,492	109,764,762	166,073,254	0	166,073,254	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-320,377	5,459,880	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-48,986	7,639,976	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-13,243	13,495,639	4.00
5.01	00540	NONPATIENT TELEPHONES	0	651,618	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	-117,393	1,252,971	5.02
5.03	00570	ADMITTING	0	1,386,957	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,929,826	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,728,311	33,966,818	5.05
7.00	00700	OPERATION OF PLANT	-358,078	6,895,724	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	968,657	8.00
9.00	00900	HOUSEKEEPING	0	1,896,204	9.00
10.00	01000	DIETARY	-908,542	2,189,948	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	520,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	570,424	14.00
15.00	01500	PHARMACY	0	9,994,734	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-111,654	1,995,662	16.00
17.00	01700	SOCIAL SERVICE	0	2,110,038	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	127,639	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-15,590	11,228,766	30.00
31.00	03100	INTENSIVE CARE UNIT	-34,188	4,491,829	31.00
40.00	04000	SUBPROVIDER - IPF	-54,276	666,715	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	777,323	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-1,382,096	5,998,972	50.00
51.00	05100	RECOVERY ROOM	0	918,237	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-41,250	1,306,946	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-382	5,407,900	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,106,981	59.00
60.00	06000	LABORATORY	-93,760	5,894,779	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	84,467	63.00
64.00	06400	INTRAVENOUS THERAPY	0	565,258	64.00
65.00	06500	RESPIRATORY THERAPY	-4,867	2,587,787	65.00
66.00	06600	PHYSICAL THERAPY	0	852,177	66.00
69.00	06900	ELECTROCARDIOLOGY	-7,200	573,151	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	108,392	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-10,323	10,757,600	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	8,850,930	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,914	37,914	73.00
74.00	07400	RENAL DIALYSIS	0	404,335	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	135,625	76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	-16,277	3,824,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	-178,811	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,407,690	159,633,696	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	SIRH	0	267,319	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	764,549	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-5,407,690	160,665,564	200.00

RECLASSIFICATIONS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/26/2015 4:18 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - INTERNS AND RESIDENTS RECLASS				
1.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	127,639	1.00
	TOTALS		0	127,639	
	B - NEW DIRECTIONS ADMIN RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	95,775	8,829	1.00
	TOTALS		95,775	8,829	
	C - INTEREST EXPENSE RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,383,136	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	42,884	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	136,900	3.00
	TOTALS		0	2,562,920	
	D - DEPRECIATION RECLASS				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	7,646,078	1.00
	TOTALS		0	7,646,078	
	E - INURANCE RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	121,058	1.00
	TOTALS		0	121,058	
	F - UTILITIES EXPENSE RECLASS				
1.00	NONPATIENT TELEPHONES	5.01	0	12,315	1.00
2.00	OPERATION OF PLANT	7.00	0	94,374	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	106,689	
	G - CHARGEABLE SUPPLIES RECLASS				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	26,369	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	180	2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	19,618,853	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	19,645,402	
	H - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	8,850,930	1.00
	TOTALS		0	8,850,930	
	I - MAINTENANCE RECLASS				
1.00	OPERATION OF PLANT	7.00	2,973	0	1.00
	TOTALS		2,973	0	
500.00	Grand Total: Increases		98,748	39,069,545	500.00

RECLASSIFICATIONS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/26/2015 4:18 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - INTERNS AND RESIDENTS RECLASS					
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	127,639	0	1.00
	TOTALS		0	127,639		
	B - NEW DIRECTIONS ADMIN RECLASS					
1.00	SUBPROVIDER - IPF	40.00	95,775	8,829	0	1.00
	TOTALS		95,775	8,829		
	C - INTEREST EXPENSE RECLASS					
1.00	INTEREST EXPENSE	113.00	0	2,562,920	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	2,562,920		
	D - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	7,646,078	9	1.00
	TOTALS		0	7,646,078		
	E - INURANCE RECLASS					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	121,058	12	1.00
	TOTALS		0	121,058		
	F - UTILITIES EXPENSE RECLASS					
1.00	NONPATIENT TELEPHONES	5.01	0	50,177	0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	1,923	0	2.00
3.00	OPERATING ROOM	50.00	0	822	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,574	0	4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	193	0	5.00
	TOTALS		0	106,689		
	G - CHARGEABLE SUPPLIES RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35,859	0	1.00
2.00	NONPATIENT TELEPHONES	5.01	0	129	0	2.00
3.00	ADMITTING	5.03	0	511	0	3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	4	0	4.00
5.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	10,399	0	5.00
6.00	OPERATION OF PLANT	7.00	0	20	0	6.00
8.00	HOUSEKEEPING	9.00	0	7,026	0	8.00
9.00	DIETARY	10.00	0	14,414	0	9.00
10.00	NURSING ADMINISTRATION	13.00	0	7,448	0	10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	0	185	0	11.00
12.00	SOCIAL SERVICE	17.00	0	58	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	0	662,765	0	13.00
14.00	INTENSIVE CARE UNIT	31.00	0	697,958	0	14.00
15.00	SUBPROVIDER - IPF	40.00	0	14,716	0	15.00
16.00	NURSERY	43.00	0	74,345	0	16.00
17.00	OPERATING ROOM	50.00	0	10,852,791	0	17.00
18.00	RECOVERY ROOM	51.00	0	208,713	0	18.00
19.00	DELIVERY ROOM & LABOR ROOM	52.00	0	253,809	0	19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,216,481	0	20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	2,592,268	0	21.00
22.00	LABORATORY	60.00	0	15,237	0	22.00
23.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	966,962	0	23.00
24.00	RESPIRATORY THERAPY	65.00	0	139,355	0	24.00
25.00	PHYSICAL THERAPY	66.00	0	12,852	0	25.00
26.00	ELECTROCARDIOLOGY	69.00	0	24,063	0	26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	509	0	27.00
28.00	EMERGENCY	91.00	0	797,327	0	28.00
29.00	SIRH	194.00	0	39,021	0	29.00
30.00	OTHER NONREIMBURSABLE COST CENTERS	194.01	0	177	0	30.00
	TOTALS		0	19,645,402		
	H - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,850,930	0	1.00
	TOTALS		0	8,850,930		
	I - MAINTENANCE RECLASS					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.01	2,973	0	0	1.00
	TOTALS		2,973	0		
500.00	Grand Total: Decreases		98,748	39,069,545		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I Date/Time Prepared: 5/26/2015 4:18 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,071,554	0	0	0	0	1.00
2.00	Land Improvements	1,543,212	0	0	0	84,232	2.00
3.00	Buildings and Fixtures	90,872,698	0	0	0	3,844,478	3.00
4.00	Building Improvements	510,456	1,061,540	0	1,061,540	0	4.00
5.00	Fixed Equipment	21,846,570	0	0	0	1,223,993	5.00
6.00	Movable Equipment	110,255,712	1,498,241	0	1,498,241	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	231,100,202	2,559,781	0	2,559,781	5,152,703	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	231,100,202	2,559,781	0	2,559,781	5,152,703	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,071,554	0	1.00
2.00	Land Improvements	1,458,980	0	2.00
3.00	Buildings and Fixtures	87,028,220	0	3.00
4.00	Building Improvements	1,571,996	0	4.00
5.00	Fixed Equipment	20,622,577	0	5.00
6.00	Movable Equipment	111,753,953	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	228,507,280	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	228,507,280	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II Date/Time Prepared: 5/26/2015 4:18 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	10,909,306	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,909,306	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	12,835	10,922,141	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	12,835	10,922,141	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/26/2015 4:18 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	116,753,327	0	116,753,327	0.510939	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	111,753,953	0	111,753,953	0.489061	0	2.00
3.00	Total (sum of lines 1-2)	228,507,280	0	228,507,280	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,955,686	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	7,597,092	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,552,778	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,383,136	121,058	0	0	5,459,880	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	42,884	0	0	0	7,639,976	2.00
3.00	Total (sum of lines 1-2)	2,426,020	121,058	0	0	13,099,856	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/26/2015 4:18 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-52,492	OTHER ADMINISTRATIVE AND GENERAL	5.05	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)	A	-7,104	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	7.00
8.00	Television and radio service (chapter 21)	A	-3,706	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,643,951			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	22,816			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-873,262	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-83,498	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	B	-35,280	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/26/2015 4:18 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	AHA & IHA DUES - LOBBYING PORTION	A	-10,032	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.00
34.00	NONALLOWABLE DEPRECIATION - BUILDING	A	-307,542	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
35.00	NONALLOWABLE DEPRECIATION - EQUIP	A	-38,176	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	35.00
36.00	UTILITIES	A	-358,078	OPERATION OF PLANT	7.00	0	36.00
37.00	TAXI EXPENSE	A	-3,928	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	37.00
38.00	ADVERTISING - PERSONNEL	A	-13,243	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	ADVERTISING - A & G	A	-1,057,910	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	39.00
40.00	ADVERTISING - A&P	A	-7,216	ADULTS & PEDIATRICS	30.00	0	40.00
41.00	ADVERTISING - PSYCH	A	-4,276	SUBPROVIDER - IPF	40.00	0	41.00
42.00	CT MARKETING CONTRACTS	A	-369	RADIOLOGY-DIAGNOSTIC	54.00	0	42.00
43.00	ER MARKETING CONTRACTS	A	-1,201	EMERGENCY	91.00	0	43.00
44.00	GOODWILL AMORTIZATION	A	-12,835	NEW CAP REL COSTS-BLDG & FIXT	1.00	14	44.00
45.00	PHYSICIAN RECRUITMENT	A	-15,239	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	45.00
46.00	DONATIONS	A	-151,437	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	46.00
47.00	INTEREST INCOME	B	-178,811	INTEREST EXPENSE	113.00	0	47.00
48.00	RENTAL INCOME	B	-36,806	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	48.00
49.00	MISCELLANEOUS INCOME - A & G	B	-388,893	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	49.00
49.01	REBATES - MATERIAL MGMT	B	-117,209	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	49.01
49.02	REBATES- OR	B	-496	OPERATING ROOM	50.00	0	49.02
49.03	CABLE TELEVISION	A	-27,516	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	49.03
49.04			0		0.00	0	49.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,407,690				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: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2015 4:18 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.05	OTHER ADMINISTRATIVE AND GEN	A&G	15,942	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	HEALTH INFORMATION MANAGEMEN	22,215	24,216	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	RADIO DIAGNOSTICS	945	958	3.00
4.00	60.00	LABORATORY	LAB ADMINISTRATION	210,479	224,239	4.00
4.01	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY	323,171	328,038	4.01
4.02	71.00	MEDICAL SUPPLIES CHARGED TO	SUPPLY AND DISTRIBUTION	115,974	126,297	4.02
4.03	73.00	DRUGS CHARGED TO PATIENTS	IV THERAPY/PHARMACY	119,081	81,167	4.03
4.04	91.00	EMERGENCY	EMERGENCY ROOM	0	76	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
5.00	0		0	807,807	784,991	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	C		0.00	SIRH	33.33	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: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/26/2015 4:18 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	15,942	0	1.00
2.00	-2,001	0	2.00
3.00	-13	0	3.00
4.00	-13,760	0	4.00
4.01	-4,867	0	4.01
4.02	-10,323	0	4.02
4.03	37,914	0	4.03
4.04	-76	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
5.00	22,816		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.

	Type of Business		
6.00	REHAB FACILITY		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: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/26/2015 4:18 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.02	OTHER ADMINISTRATIVE AND GENERAL	184	184	0	177,200	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	26,155	26,155	0	177,200	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	8,374	8,374	0	177,200	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	34,188	34,188	0	177,200	0	4.00
5.00	40.00	SUBPROVIDER - IPF	50,000	50,000	0	154,100	0	5.00
6.00	50.00	OPERATING ROOM	1,381,600	1,381,600	0	208,000	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	41,250	41,250	0	196,400	0	7.00
8.00	60.00	LABORATORY	80,000	80,000	0	215,700	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	7,200	7,200	0	225,300	0	9.00
10.00	91.00	EMERGENCY	15,000	15,000	0	177,200	0	10.00
200.00			1,643,951	1,643,951	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.02	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.02	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	184	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	0	0	26,155	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	8,374	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	34,188	4.00
5.00	40.00	SUBPROVIDER - IPF	0	0	0	50,000	5.00
6.00	50.00	OPERATING ROOM	0	0	0	1,381,600	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	41,250	7.00
8.00	60.00	LABORATORY	0	0	0	80,000	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	7,200	9.00
10.00	91.00	EMERGENCY	0	0	0	15,000	10.00
200.00			0	0	0	1,643,951	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	5,459,880	5,459,880				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	7,639,976		7,639,976			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,495,639	0	0	13,495,639		4.00
5.01	00540	NONPATIENT TELEPHONES	651,618	0	0	70,067	721,685	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,252,971	28,433	39,786	147,856	10,634	5.02
5.03	00570	ADMITTING	1,386,957	209,793	293,563	288,974	9,925	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,929,826	310,244	434,122	220,649	32,611	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	33,966,818	504,209	705,537	1,163,531	208,422	5.05
7.00	00700	OPERATION OF PLANT	6,895,724	839,519	1,174,734	271,138	19,850	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	968,657	0	0	30,539	1,418	8.00
9.00	00900	HOUSEKEEPING	1,896,204	0	0	379,724	0	9.00
10.00	01000	DIETARY	2,189,948	263,796	369,128	332,494	12,052	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	520,425	45,124	63,142	117,923	3,545	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	570,424	87,371	122,257	88,805	5,671	14.00
15.00	01500	PHARMACY	9,994,734	53,873	75,384	620,357	9,925	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,995,662	0	0	343,645	32,611	16.00
17.00	01700	SOCIAL SERVICE	2,110,038	0	0	408,997	12,052	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	127,639	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,228,766	1,096,018	1,533,653	2,611,915	58,132	30.00
31.00	03100	INTENSIVE CARE UNIT	4,491,829	106,062	148,412	1,036,083	19,141	31.00
40.00	04000	SUBPROVIDER - IPF	666,715	235,176	329,080	154,467	7,089	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	777,323	0	0	180,979	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	5,998,972	403,485	564,595	966,514	49,625	50.00
51.00	05100	RECOVERY ROOM	918,237	0	0	217,320	9,925	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,306,946	219,765	307,516	294,170	9,925	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,407,900	400,579	560,527	993,898	35,446	54.00
59.00	05900	CARDIAC CATHETERIZATION	1,106,981	92,090	128,861	230,626	14,887	59.00
60.00	06000	LABORATORY	5,894,779	164,727	230,501	635,210	25,521	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	84,467	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	565,258	0	0	49,239	2,127	64.00
65.00	06500	RESPIRATORY THERAPY	2,587,787	0	0	399,278	0	65.00
66.00	06600	PHYSICAL THERAPY	852,177	0	0	203,279	4,962	66.00
69.00	06900	ELECTROCARDIOLOGY	573,151	54,564	76,350	130,594	8,507	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	108,392	8,864	12,403	12,297	3,545	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,757,600	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,850,930	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,914	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	404,335	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	135,625	0	0	29,858	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,824,472	291,811	408,330	787,768	36,155	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	159,633,696	5,415,503	7,577,881	13,418,194	643,703	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,742	16,430	0	2,836	190.00
194.00	07950	SIRH	267,319	0	0	61,873	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	764,549	32,635	45,665	15,572	75,146	194.01
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)	160,665,564	5,459,880	7,639,976	13,495,639	721,685	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,479,680					5.02
5.03	00570	ADMITTING	18,947	2,208,159				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	10	0	2,927,462			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	1,300	0	0	36,549,817	36,549,817	5.05
7.00	00700	OPERATION OF PLANT	672	0	0	9,201,637	2,709,716	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,377	0	0	1,007,991	296,835	8.00
9.00	00900	HOUSEKEEPING	51,030	0	0	2,326,958	685,247	9.00
10.00	01000	DIETARY	20,194	0	0	3,187,612	938,694	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,786	0	0	752,945	221,729	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	874,528	257,533	14.00
15.00	01500	PHARMACY	54,174	0	0	10,808,447	3,182,893	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	190	0	0	2,372,108	698,543	16.00
17.00	01700	SOCIAL SERVICE	3	0	0	2,531,090	745,360	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	127,639	37,587	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,737	122,638	162,582	16,895,441	4,975,370	30.00
31.00	03100	INTENSIVE CARE UNIT	58,599	44,358	58,806	5,963,290	1,756,082	31.00
40.00	04000	SUBPROVIDER - IPF	4,364	7,637	10,125	1,414,653	416,590	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,177	6,544	8,676	978,699	288,209	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	66,356	191,905	254,410	8,495,862	2,501,878	50.00
51.00	05100	RECOVERY ROOM	5,495	29,334	38,888	1,219,199	359,032	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,562	13,042	17,290	2,202,216	648,513	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,765	467,978	620,497	8,519,590	2,508,866	54.00
59.00	05900	CARDIAC CATHETERIZATION	6,963	71,748	95,116	1,747,272	514,540	59.00
60.00	06000	LABORATORY	898,956	248,055	328,847	8,426,596	2,481,481	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	45,635	95,216	126,228	351,546	103,524	63.00
64.00	06400	INTRAVENOUS THERAPY	14,231	51,776	68,639	751,270	221,235	64.00
65.00	06500	RESPIRATORY THERAPY	2,907	101,626	134,726	3,226,324	950,094	65.00
66.00	06600	PHYSICAL THERAPY	1,838	16,244	21,535	1,100,035	323,941	66.00
69.00	06900	ELECTROCARDIOLOGY	3,215	54,750	72,582	973,713	286,741	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,287	9,809	13,003	169,600	49,944	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	285,931	379,060	11,422,591	3,363,747	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	99,178	131,481	9,081,589	2,674,364	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	172,396	228,546	438,856	129,235	73.00
74.00	07400	RENAL DIALYSIS	0	2,235	2,963	409,533	120,600	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	150	3,474	4,606	173,713	51,155	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	58,583	112,285	148,856	5,668,260	1,669,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,478,503	2,208,159	2,927,462	159,370,620	36,168,479	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	31,008	9,131	190.00
194.00	07950	SIRH	980	0	0	330,172	97,230	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	197	0	0	933,764	274,977	194.01
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)	1,479,680	2,208,159	2,927,462	160,665,564	36,549,817	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	11,911,353					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,304,826				8.00
9.00	00900	HOUSEKEEPING	0	0	3,012,205			9.00
10.00	01000	DIETARY	880,730	0	6,815	5,013,851		10.00
11.00	01100	CAFETERIA	0	0	0	3,649,285	3,649,285	11.00
13.00	01300	NURSING ADMINISTRATION	150,656	0	0	0	27,205	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	291,703	0	27,260	0	0	14.00
15.00	01500	PHARMACY	179,864	0	9,541	0	193,441	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	6,133	0	148,973	16.00
17.00	01700	SOCIAL SERVICE	0	0	681	0	114,933	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,659,261	808,990	1,565,395	1,166,493	1,028,995	30.00
31.00	03100	INTENSIVE CARE UNIT	354,108	91,338	436,156	150,937	381,855	31.00
40.00	04000	SUBPROVIDER - IPF	785,177	0	173,781	14,469	62,458	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	13,048	681	0	50,280	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,347,109	117,435	116,536	0	305,044	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,623	66,057	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	733,725	26,097	173,781	2,288	95,015	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,337,405	65,242	79,735	0	317,025	54.00
59.00	05900	CARDIAC CATHETERIZATION	307,460	13,048	34,075	0	59,039	59.00
60.00	06000	LABORATORY	549,970	0	54,520	0	235,275	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	681	0	12,159	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	681	0	133,521	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,044	0	48,040	66.00
69.00	06900	ELECTROCARDIOLOGY	182,170	0	6,133	0	43,102	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,593	0	1,363	0	3,537	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	2,044	0	12,507	76.01
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	974,265	91,338	314,169	26,756	283,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,763,196	1,226,536	3,012,205	5,013,851	3,621,507	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,201	0	0	0	0	190.00
194.00	07950	SIRH	0	0	0	0	20,874	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	108,956	78,290	0	0	6,904	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,911,353	1,304,826	3,012,205	5,013,851	3,649,285	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	16A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,152,535					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,451,024				14.00
15.00	01500	PHARMACY	0	0	14,374,186			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,225,757		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	3,392,064	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	165,226	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	505,962	0	0	274,874	30,880,781	30.00
31.00	03100	INTENSIVE CARE UNIT	187,761	0	0	51,269	9,372,796	31.00
40.00	04000	SUBPROVIDER - IPF	30,711	0	0	14,270	2,912,109	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	24,723	0	0	110,652	1,466,292	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,992	0	0	324,590	13,358,446	50.00
51.00	05100	RECOVERY ROOM	32,481	0	0	0	1,680,392	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,720	0	0	8,459	3,936,814	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,240,357	14,068,220	54.00
59.00	05900	CARDIAC CATHETERIZATION	29,030	0	0	47,759	2,752,223	59.00
60.00	06000	LABORATORY	0	0	0	75,091	11,822,933	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	455,070	63.00
64.00	06400	INTRAVENOUS THERAPY	5,979	0	0	185,455	1,176,779	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	4,310,620	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,474,060	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,491,859	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	254,037	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	798,063	0	0	15,584,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	652,961	0	0	12,408,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	14,374,186	0	14,942,277	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	530,133	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	239,419	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	139,176	0	0	892,981	10,059,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,152,535	1,451,024	14,374,186	3,225,757	158,735,057	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	79,340	190.00
194.00	07950	SIRH	0	0	0	0	448,276	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	1,402,891	194.01
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)	1,152,535	1,451,024	14,374,186	3,225,757	160,665,564	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.00	21.00	22.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	3,392,064					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	3,564	0	168,790			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	666,027	0	168,790	31,715,598	-168,790	30.00
31.00	03100	INTENSIVE CARE UNIT	202,152	0	0	9,574,948	0	31.00
40.00	04000	SUBPROVIDER - IPF	62,808	0	0	2,974,917	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	31,625	0	0	1,497,917	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	288,115	0	0	13,646,561	0	50.00
51.00	05100	RECOVERY ROOM	36,243	0	0	1,716,635	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,909	0	0	4,021,723	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	303,423	0	0	14,371,643	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	59,360	0	0	2,811,583	0	59.00
60.00	06000	LABORATORY	254,997	0	0	12,077,930	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,815	0	0	464,885	0	63.00
64.00	06400	INTRAVENOUS THERAPY	25,381	0	0	1,202,160	0	64.00
65.00	06500	RESPIRATORY THERAPY	92,971	0	0	4,403,591	0	65.00
66.00	06600	PHYSICAL THERAPY	31,793	0	0	1,505,853	0	66.00
69.00	06900	ELECTROCARDIOLOGY	32,176	0	0	1,524,035	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,479	0	0	259,516	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	336,124	0	0	15,920,525	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	267,635	0	0	12,676,549	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	322,275	0	0	15,264,552	0	73.00
74.00	07400	RENAL DIALYSIS	11,434	0	0	541,567	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	5,164	0	0	244,583	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	216,957	0	0	10,276,149	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,350,427	0	168,790	158,693,420	-168,790	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,711	0	0	81,051	0	190.00
194.00	07950	SIRH	9,668	0	0	457,944	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	30,258	0	0	1,433,149	0	194.01
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,392,064	0	168,790	160,665,564	-168,790	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL			5.02
5.03	00570	ADMITTING			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	31,546,808		30.00
31.00	03100	INTENSIVE CARE UNIT	9,574,948		31.00
40.00	04000	SUBPROVIDER - IPF	2,974,917		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVIDER	0		42.00
43.00	04300	NURSERY	1,497,917		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	13,646,561		50.00
51.00	05100	RECOVERY ROOM	1,716,635		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,021,723		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,371,643		54.00
59.00	05900	CARDIAC CATHETERIZATION	2,811,583		59.00
60.00	06000	LABORATORY	12,077,930		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	464,885		63.00
64.00	06400	INTRAVENOUS THERAPY	1,202,160		64.00
65.00	06500	RESPIRATORY THERAPY	4,403,591		65.00
66.00	06600	PHYSICAL THERAPY	1,505,853		66.00
69.00	06900	ELECTROCARDIOLOGY	1,524,035		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	259,516		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,920,525		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,676,549		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,264,552		73.00
74.00	07400	RENAL DIALYSIS	541,567		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	244,583		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	10,276,149		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	158,524,630		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	81,051		190.00
194.00	07950	SIRH	457,944		194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	1,433,149		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	160,496,774		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	28,433	39,786	68,219	0	5.02
5.03	00570	ADMITTING	0	209,793	293,563	503,356	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	310,244	434,122	744,366	0	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	504,209	705,537	1,209,746	0	5.05
7.00	00700	OPERATION OF PLANT	0	839,519	1,174,734	2,014,253	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	263,796	369,128	632,924	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	45,124	63,142	108,266	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	87,371	122,257	209,628	0	14.00
15.00	01500	PHARMACY	0	53,873	75,384	129,257	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,096,018	1,533,653	2,629,671	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	106,062	148,412	254,474	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	235,176	329,080	564,256	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	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	0	403,485	564,595	968,080	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	219,765	307,516	527,281	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	400,579	560,527	961,106	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	92,090	128,861	220,951	0	59.00
60.00	06000	LABORATORY	0	164,727	230,501	395,228	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	54,564	76,350	130,914	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,864	12,403	21,267	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	291,811	408,330	700,141	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,415,503	7,577,881	12,993,384	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,742	16,430	28,172	0	190.00
194.00	07950	SIRH	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	32,635	45,665	78,300	0	194.01
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)	0	5,459,880	7,639,976	13,099,856	0	202.00

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		Cost Center Description	NONPATIENT TELEPHONES	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	68,219				5.02
5.03	00570	ADMITTING	0	873	504,229			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	744,366		5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	60	0	0	1,209,806	5.05
7.00	00700	OPERATION OF PLANT	0	31	0	0	89,688	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	340	0	0	9,825	8.00
9.00	00900	HOUSEKEEPING	0	2,353	0	0	22,681	9.00
10.00	01000	DIETARY	0	931	0	0	31,070	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	128	0	0	7,339	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	8,524	14.00
15.00	01500	PHARMACY	0	2,498	0	0	105,350	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9	0	0	23,121	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	24,671	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	1,244	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,768	27,995	41,335	164,728	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,702	10,126	14,951	58,124	31.00
40.00	04000	SUBPROVIDER - IPF	0	201	1,743	2,574	13,789	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	239	1,494	2,206	9,539	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	3,059	43,807	64,681	82,809	50.00
51.00	05100	RECOVERY ROOM	0	253	6,696	9,887	11,884	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,547	2,977	4,396	21,465	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,511	106,990	157,843	83,040	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	321	16,378	24,182	17,031	59.00
60.00	06000	LABORATORY	0	41,447	56,625	83,606	82,134	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,104	21,735	32,092	3,427	63.00
64.00	06400	INTRAVENOUS THERAPY	0	656	11,819	17,451	7,323	64.00
65.00	06500	RESPIRATORY THERAPY	0	134	23,199	34,253	31,447	65.00
66.00	06600	PHYSICAL THERAPY	0	85	3,708	5,475	10,722	66.00
69.00	06900	ELECTROCARDIOLOGY	0	148	12,498	18,453	9,491	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	59	2,239	3,306	1,653	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	65,271	96,372	111,336	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	22,640	33,428	88,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	39,354	58,106	4,278	73.00
74.00	07400	RENAL DIALYSIS	0	0	510	753	3,992	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	7	793	1,171	1,693	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	2,701	25,632	37,845	55,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	68,165	504,229	744,366	1,197,185	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	302	190.00
194.00	07950	SIRH	0	45	0	0	3,218	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	9	0	0	9,101	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	68,219	504,229	744,366	1,209,806	202.00

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		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	2,103,972					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,165				8.00
9.00	00900	HOUSEKEEPING	0	0	25,034			9.00
10.00	01000	DIETARY	155,568	0	57	820,550		10.00
11.00	01100	CAFETERIA	0	0	0	597,230	597,230	11.00
13.00	01300	NURSING ADMINISTRATION	26,611	0	0	0	4,452	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51,525	0	227	0	0	14.00
15.00	01500	PHARMACY	31,770	0	79	0	31,658	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	51	0	24,380	16.00
17.00	01700	SOCIAL SERVICE	0	0	6	0	18,810	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	646,358	6,301	13,008	190,904	168,401	30.00
31.00	03100	INTENSIVE CARE UNIT	62,548	712	3,625	24,702	62,493	31.00
40.00	04000	SUBPROVIDER - IPF	138,690	0	1,444	2,368	10,222	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	102	6	0	8,229	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	237,948	915	969	0	49,923	50.00
51.00	05100	RECOVERY ROOM	0	0	0	593	10,811	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	129,602	203	1,444	374	15,550	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	236,234	508	663	0	51,883	54.00
59.00	05900	CARDIAC CATHETERIZATION	54,309	102	283	0	9,662	59.00
60.00	06000	LABORATORY	97,144	0	453	0	38,504	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	6	0	1,990	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	6	0	21,852	65.00
66.00	06600	PHYSICAL THERAPY	0	0	17	0	7,862	66.00
69.00	06900	ELECTROCARDIOLOGY	32,178	0	51	0	7,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,227	0	11	0	579	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	17	0	2,047	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	172,090	712	2,611	4,379	46,322	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,077,802	9,555	25,034	820,550	592,684	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,924	0	0	0	0	190.00
194.00	07950	SIRH	0	0	0	0	3,416	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	19,246	610	0	0	1,130	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,103,972	10,165	25,034	820,550	597,230	202.00

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		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	146,796					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	269,904				14.00
15.00	01500	PHARMACY	0	0	300,612			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	47,561		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	43,487	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	46	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,443	0	0	4,053	8,479	30.00
31.00	03100	INTENSIVE CARE UNIT	23,915	0	0	756	2,596	31.00
40.00	04000	SUBPROVIDER - IPF	3,912	0	0	210	807	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	3,149	0	0	1,631	406	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,104	0	0	4,786	3,700	50.00
51.00	05100	RECOVERY ROOM	4,137	0	0	0	465	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,951	0	0	125	1,090	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,289	3,897	54.00
59.00	05900	CARDIAC CATHETERIZATION	3,697	0	0	704	762	59.00
60.00	06000	LABORATORY	0	0	0	1,107	3,275	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	126	63.00
64.00	06400	INTRAVENOUS THERAPY	761	0	0	2,734	326	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1,194	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	408	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	413	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	148,447	0	0	4,317	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	121,457	0	0	3,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	300,612	0	4,139	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	147	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	66	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	17,727	0	0	13,166	2,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	146,796	269,904	300,612	47,561	42,952	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	22	190.00
194.00	07950	SIRH	0	0	0	0	124	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	389	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	146,796	269,904	300,612	47,561	43,487	202.00

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		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			21.00	22.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		1,290				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			3,969,444	0	3,969,444	30.00
31.00	03100	INTENSIVE CARE UNIT			521,724	0	521,724	31.00
40.00	04000	SUBPROVIDER - IPF			740,216	0	740,216	40.00
41.00	04100	SUBPROVIDER - IRF			0	0	0	41.00
42.00	04200	SUBPROVIDER			0	0	0	42.00
43.00	04300	NURSERY			27,001	0	27,001	43.00
44.00	04400	SKILLED NURSING FACILITY			0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			1,479,781	0	1,479,781	50.00
51.00	05100	RECOVERY ROOM			44,726	0	44,726	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			712,005	0	712,005	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			1,621,964	0	1,621,964	54.00
59.00	05900	CARDIAC CATHETERIZATION			348,382	0	348,382	59.00
60.00	06000	LABORATORY			799,523	0	799,523	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.			59,484	0	59,484	63.00
64.00	06400	INTRAVENOUS THERAPY			43,066	0	43,066	64.00
65.00	06500	RESPIRATORY THERAPY			112,085	0	112,085	65.00
66.00	06600	PHYSICAL THERAPY			28,277	0	28,277	66.00
69.00	06900	ELECTROCARDIOLOGY			211,200	0	211,200	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			34,411	0	34,411	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			425,743	0	425,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT			269,480	0	269,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			406,489	0	406,489	73.00
74.00	07400	RENAL DIALYSIS			5,402	0	5,402	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS			0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS			5,794	0	5,794	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY			1,081,361	0	1,081,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	12,947,558	0	12,947,558	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			35,420	0	35,420	190.00
194.00	07950	SIRH			6,803	0	6,803	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS			108,785	0	108,785	194.01
200.00		Cross Foot Adjustments	0	1,290	1,290	0	1,290	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,290	13,099,856	0	13,099,856	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONES)	OTHER ADMINISTRATIVE AND GENERAL (SUPPLIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	379,445					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		379,445				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	55,930,435			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	290,382	1,018		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,976	1,976	612,767	15	2,612,512	5.02
5.03	00570	ADMITTING	14,580	14,580	1,197,605	14	33,452	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	21,561	21,561	914,446	46	17	5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	35,041	35,041	4,822,065	294	2,295	5.05
7.00	00700	OPERATION OF PLANT	58,344	58,344	1,123,687	28	1,187	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	126,562	2	13,024	8.00
9.00	00900	HOUSEKEEPING	0	0	1,573,703	0	90,098	9.00
10.00	01000	DIETARY	18,333	18,333	1,377,967	17	35,655	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,136	3,136	488,712	5	4,919	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,072	6,072	368,038	8	0	14.00
15.00	01500	PHARMACY	3,744	3,744	2,570,970	14	95,649	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,424,181	46	335	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,695,022	17	5	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	76,170	76,170	10,824,595	82	144,314	30.00
31.00	03100	INTENSIVE CARE UNIT	7,371	7,371	4,293,878	27	103,462	31.00
40.00	04000	SUBPROVIDER - IPF	16,344	16,344	640,164	10	7,705	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	750,040	0	9,140	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,041	28,041	4,005,560	70	117,158	50.00
51.00	05100	RECOVERY ROOM	0	0	900,647	14	9,702	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,273	15,273	1,219,139	14	59,257	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,839	27,839	4,119,052	50	57,850	54.00
59.00	05900	CARDIAC CATHETERIZATION	6,400	6,400	955,791	21	12,294	59.00
60.00	06000	LABORATORY	11,448	11,448	2,632,526	36	1,587,192	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	80,572	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	204,063	3	25,127	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,654,745	0	5,133	65.00
66.00	06600	PHYSICAL THERAPY	0	0	842,458	7	3,246	66.00
69.00	06900	ELECTROCARDIOLOGY	3,792	3,792	541,227	12	5,676	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	616	616	50,964	5	2,272	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	123,741	0	265	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	20,280	20,280	3,264,778	51	103,433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	376,361	376,361	55,609,475	908	2,610,434	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	816	816	0	4	0	190.00
194.00	07950	SIRH	0	0	256,424	0	1,730	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	2,268	2,268	64,536	106	348	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,459,880	7,639,976	13,495,639	721,685	1,479,680	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.389121	20.134607	0.241293	708.924361	0.566382	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0	68,219	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	0.026112	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
5.03	00570	ADMITTING	447,273,181					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	447,273,181				5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	-36,549,817	124,115,747		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	9,201,637	247,943	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	1,007,991	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,326,958	0	9.00
10.00	01000	DIETARY	0	0	0	3,187,612	18,333	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	752,945	3,136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	874,528	6,072	14.00
15.00	01500	PHARMACY	0	0	0	10,808,447	3,744	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,372,108	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,531,090	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	127,639	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,840,584	24,840,584	0	16,895,441	76,170	30.00
31.00	03100	INTENSIVE CARE UNIT	8,984,815	8,984,815	0	5,963,290	7,371	31.00
40.00	04000	SUBPROVIDER - IPF	1,546,975	1,546,975	0	1,414,653	16,344	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,325,541	1,325,541	0	978,699	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	38,870,840	38,870,840	0	8,495,862	28,041	50.00
51.00	05100	RECOVERY ROOM	5,941,687	5,941,687	0	1,219,199	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,641,639	2,641,639	0	2,202,216	15,273	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,795,855	94,795,855	0	8,519,590	27,839	54.00
59.00	05900	CARDIAC CATHETERIZATION	14,532,696	14,532,696	0	1,747,272	6,400	59.00
60.00	06000	LABORATORY	50,244,045	50,244,045	0	8,426,596	11,448	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	19,286,117	19,286,117	0	351,546	0	63.00
64.00	06400	INTRAVENOUS THERAPY	10,487,265	10,487,265	0	751,270	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,584,582	20,584,582	0	3,226,324	0	65.00
66.00	06600	PHYSICAL THERAPY	3,290,237	3,290,237	0	1,100,035	0	66.00
69.00	06900	ELECTROCARDIOLOGY	11,089,636	11,089,636	0	973,713	3,792	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,986,757	1,986,757	0	169,600	616	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,916,022	57,916,022	0	11,422,591	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	20,088,717	20,088,717	0	9,081,589	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,919,248	34,919,248	0	438,856	0	73.00
74.00	07400	RENAL DIALYSIS	452,657	452,657	0	409,533	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	703,762	703,762	0	173,713	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	22,743,504	22,743,504	0	5,668,260	20,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	447,273,181	447,273,181	-36,549,817	122,820,803	244,859	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	31,008	816	190.00
194.00	07950	SIRH	0	0	0	330,172	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	933,764	2,268	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,208,159	2,927,462		36,549,817	11,911,353	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004937	0.006545		0.294482	48.040691	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	504,229	744,366		1,209,806	2,103,972	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001127	0.001664		0.009747	8.485708	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING 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
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,152,531					8.00
9.00	00900	HOUSEKEEPING	0	4,420				9.00
10.00	01000	DIETARY	0	10	615,764			10.00
11.00	01100	CAFETERIA	0	0	448,178	1,763,246		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	13,145	1,132,538	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	40	0	0	0	14.00
15.00	01500	PHARMACY	0	14	0	93,466	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9	0	71,980	0	16.00
17.00	01700	SOCIAL SERVICE	0	1	0	55,533	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	714,569	2,297	143,260	497,185	497,185	30.00
31.00	03100	INTENSIVE CARE UNIT	80,677	640	18,537	184,503	184,503	31.00
40.00	04000	SUBPROVIDER - IPF	0	255	1,777	30,178	30,178	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	11,525	1	0	24,294	24,294	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,728	171	0	147,390	147,390	50.00
51.00	05100	RECOVERY ROOM	0	0	445	31,917	31,917	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,051	255	281	45,909	45,909	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,627	117	0	153,179	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	11,525	50	0	28,526	28,526	59.00
60.00	06000	LABORATORY	0	80	0	113,679	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1	0	5,875	5,875	64.00
65.00	06500	RESPIRATORY THERAPY	0	1	0	64,514	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3	0	23,212	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9	0	20,826	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2	0	1,709	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	3	0	6,043	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	80,677	461	3,286	136,761	136,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,083,379	4,420	615,764	1,749,824	1,132,538	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	SIRH	0	0	0	10,086	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	69,152	0	0	3,336	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,304,826	3,012,205	5,013,851	3,649,285	1,152,535	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.132140	681.494344	8.142488	2.069640	1.017657	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,165	25,034	820,550	597,230	146,796	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008820	5.663801	1.332572	0.338711	0.129617	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	Reconciliation	SOCIAL SERVICE (ACCUM. COST)	
			14.00	15.00	16.00	17A	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	56,060			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	-3,392,064	157,273,500	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	165,226	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,777	0	30,880,781	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	891	0	9,372,796	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	248	0	2,912,109	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	1,923	0	1,466,292	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	0	5,641	0	13,358,446	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	1,680,392	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	147	0	3,936,814	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	21,556	0	14,068,220	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	830	0	2,752,223	59.00
60.00	06000	LABORATORY	0	0	1,305	0	11,822,933	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	455,070	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,223	0	1,176,779	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	4,310,620	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	1,474,060	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,491,859	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	254,037	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55	0	0	0	15,584,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45	0	0	0	12,408,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0	0	14,942,277	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	530,133	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	239,419	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	15,519	0	10,059,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	56,060	-3,392,064	155,342,993	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	79,340	190.00
194.00	07950	SIRH	0	0	0	0	448,276	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	1,402,891	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,451,024	14,374,186	3,225,757		3,392,064	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14,510.240000	143,741.860000	57.541152		0.021568	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	269,904	300,612	47,561		43,487	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2,699.040000	3,006.120000	0.848395		0.000277	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/26/2015 4:18 pm

		Cost Center Description	INTERNS & RESIDENTS		
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
			21.00	22.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL			5.02
5.03	00570	ADMITTING			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05	00560	OTHER ADMINISTRATIVE AND GENERAL			5.05
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	100		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		100	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	100	100	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	SIRH	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	168,790	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1,687.900000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,290	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	12.900000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/26/2015 4:18 pm

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		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	31,546,808		31,546,808	0	31,546,808	30.00
31.00	03100	INTENSIVE CARE UNIT	9,574,948		9,574,948	0	9,574,948	31.00
40.00	04000	SUBPROVIDER - IPF	2,974,917		2,974,917	0	2,974,917	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,497,917		1,497,917	0	1,497,917	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,646,561		13,646,561	0	13,646,561	50.00
51.00	05100	RECOVERY ROOM	1,716,635		1,716,635	0	1,716,635	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,021,723		4,021,723	0	4,021,723	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,371,643		14,371,643	0	14,371,643	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,811,583		2,811,583	0	2,811,583	59.00
60.00	06000	LABORATORY	12,077,930		12,077,930	0	12,077,930	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	464,885		464,885	0	464,885	63.00
64.00	06400	INTRAVENOUS THERAPY	1,202,160		1,202,160	0	1,202,160	64.00
65.00	06500	RESPIRATORY THERAPY	4,403,591	0	4,403,591	0	4,403,591	65.00
66.00	06600	PHYSICAL THERAPY	1,505,853	0	1,505,853	0	1,505,853	66.00
69.00	06900	ELECTROCARDIOLOGY	1,524,035		1,524,035	0	1,524,035	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	259,516		259,516	0	259,516	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,920,525		15,920,525	0	15,920,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,676,549		12,676,549	0	12,676,549	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,264,552		15,264,552	0	15,264,552	73.00
74.00	07400	RENAL DIALYSIS	541,567		541,567	0	541,567	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	244,583		244,583	0	244,583	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,276,149		10,276,149	0	10,276,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,076,312		3,076,312		3,076,312	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	161,600,942	0	161,600,942	0	161,600,942	200.00
201.00		Less Observation Beds	3,076,312		3,076,312		3,076,312	201.00
202.00		Total (see instructions)	158,524,630	0	158,524,630	0	158,524,630	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/26/2015 4:18 pm

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		Cost Center Description	Charges Inpatient	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	23,139,024		23,139,024			30.00
31.00	03100	INTENSIVE CARE UNIT	8,984,815		8,984,815			31.00
40.00	04000	SUBPROVIDER - IPF	1,546,975		1,546,975			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,325,541		1,325,541			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,224,975	27,645,865	38,870,840	0.351075	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,318,631	3,623,056	5,941,687	0.288914	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,306,141	335,498	2,641,639	1.522435	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,813,752	66,982,103	94,795,855	0.151606	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,960,039	6,572,657	14,532,696	0.193466	0.000000	59.00
60.00	06000	LABORATORY	30,028,928	20,215,117	50,244,045	0.240385	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,494,236	6,791,881	19,286,117	0.024105	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,993,527	6,493,738	10,487,265	0.114630	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	15,770,235	4,814,347	20,584,582	0.213927	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,136,342	153,895	3,290,237	0.457673	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	5,563,598	5,526,038	11,089,636	0.137429	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	381,886	1,604,871	1,986,757	0.130623	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,749,548	22,166,474	57,916,022	0.274890	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,504,149	4,584,568	20,088,717	0.631028	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,258,140	13,661,108	34,919,248	0.437139	0.000000	73.00
74.00	07400	RENAL DIALYSIS	438,037	14,620	452,657	1.196418	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	810	702,952	703,762	0.347537	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,909,057	16,834,447	22,743,504	0.451828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	260,305	1,441,255	1,701,560	1.807936	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	237,108,691	210,164,490	447,273,181			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	237,108,691	210,164,490	447,273,181			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/26/2015 4:18 pm

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		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
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.351075	50.00
51.00	05100	RECOVERY ROOM	0.288914	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522435	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151606	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.193466	59.00
60.00	06000	LABORATORY	0.240385	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.024105	63.00
64.00	06400	INTRAVENOUS THERAPY	0.114630	64.00
65.00	06500	RESPIRATORY THERAPY	0.213927	65.00
66.00	06600	PHYSICAL THERAPY	0.457673	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137429	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.130623	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.631028	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437139	73.00
74.00	07400	RENAL DIALYSIS	1.196418	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.347537	76.01
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.451828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.807936	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/26/2015 4:18 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	31,546,808		31,546,808	0	31,546,808	30.00
31.00	03100	INTENSIVE CARE UNIT	9,574,948		9,574,948	0	9,574,948	31.00
40.00	04000	SUBPROVIDER - IPF	2,974,917		2,974,917	0	2,974,917	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	1,497,917		1,497,917	0	1,497,917	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,646,561		13,646,561	0	13,646,561	50.00
51.00	05100	RECOVERY ROOM	1,716,635		1,716,635	0	1,716,635	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,021,723		4,021,723	0	4,021,723	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,371,643		14,371,643	0	14,371,643	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,811,583		2,811,583	0	2,811,583	59.00
60.00	06000	LABORATORY	12,077,930		12,077,930	0	12,077,930	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	464,885		464,885	0	464,885	63.00
64.00	06400	INTRAVENOUS THERAPY	1,202,160		1,202,160	0	1,202,160	64.00
65.00	06500	RESPIRATORY THERAPY	4,403,591	0	4,403,591	0	4,403,591	65.00
66.00	06600	PHYSICAL THERAPY	1,505,853	0	1,505,853	0	1,505,853	66.00
69.00	06900	ELECTROCARDIOLOGY	1,524,035		1,524,035	0	1,524,035	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	259,516		259,516	0	259,516	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,920,525		15,920,525	0	15,920,525	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,676,549		12,676,549	0	12,676,549	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,264,552		15,264,552	0	15,264,552	73.00
74.00	07400	RENAL DIALYSIS	541,567		541,567	0	541,567	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	244,583		244,583	0	244,583	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,276,149		10,276,149	0	10,276,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,076,312		3,076,312		3,076,312	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	161,600,942	0	161,600,942	0	161,600,942	200.00
201.00		Less Observation Beds	3,076,312		3,076,312		3,076,312	201.00
202.00		Total (see instructions)	158,524,630	0	158,524,630	0	158,524,630	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/26/2015 4:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges					
			Inpatient	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	23,139,024		23,139,024			30.00
31.00	03100	INTENSIVE CARE UNIT	8,984,815		8,984,815			31.00
40.00	04000	SUBPROVIDER - IPF	1,546,975		1,546,975			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,325,541		1,325,541			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,224,975	27,645,865	38,870,840	0.351075	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,318,631	3,623,056	5,941,687	0.288914	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,306,141	335,498	2,641,639	1.522435	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,813,752	66,982,103	94,795,855	0.151606	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	7,960,039	6,572,657	14,532,696	0.193466	0.000000	59.00
60.00	06000	LABORATORY	30,028,928	20,215,117	50,244,045	0.240385	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,494,236	6,791,881	19,286,117	0.024105	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,993,527	6,493,738	10,487,265	0.114630	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	15,770,235	4,814,347	20,584,582	0.213927	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,136,342	153,895	3,290,237	0.457673	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	5,563,598	5,526,038	11,089,636	0.137429	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	381,886	1,604,871	1,986,757	0.130623	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35,749,548	22,166,474	57,916,022	0.274890	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,504,149	4,584,568	20,088,717	0.631028	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,258,140	13,661,108	34,919,248	0.437139	0.000000	73.00
74.00	07400	RENAL DIALYSIS	438,037	14,620	452,657	1.196418	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	810	702,952	703,762	0.347537	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,909,057	16,834,447	22,743,504	0.451828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	260,305	1,441,255	1,701,560	1.807936	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	237,108,691	210,164,490	447,273,181			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	237,108,691	210,164,490	447,273,181			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/26/2015 4:18 pm

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
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.351075	50.00
51.00	05100	RECOVERY ROOM	0.288914	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522435	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151606	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.193466	59.00
60.00	06000	LABORATORY	0.240385	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.024105	63.00
64.00	06400	INTRAVENOUS THERAPY	0.114630	64.00
65.00	06500	RESPIRATORY THERAPY	0.213927	65.00
66.00	06600	PHYSICAL THERAPY	0.457673	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137429	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.130623	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.631028	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437139	73.00
74.00	07400	RENAL DIALYSIS	1.196418	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.347537	76.01
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.451828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.807936	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II | Date/Time Prepared: 5/26/2015 4:18 pm

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	13,646,561	1,479,781	12,166,780	0	0	50.00
51.00	05100	RECOVERY ROOM	1,716,635	44,726	1,671,909	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,021,723	712,005	3,309,718	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,371,643	1,621,964	12,749,679	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,811,583	348,382	2,463,201	0	0	59.00
60.00	06000	LABORATORY	12,077,930	799,523	11,278,407	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	464,885	59,484	405,401	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,202,160	43,066	1,159,094	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,403,591	112,085	4,291,506	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,505,853	28,277	1,477,576	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,524,035	211,200	1,312,835	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	259,516	34,411	225,105	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,920,525	425,743	15,494,782	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,676,549	269,480	12,407,069	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,264,552	406,489	14,858,063	0	0	73.00
74.00	07400	RENAL DIALYSIS	541,567	5,402	536,165	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	244,583	5,794	238,789	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,276,149	1,081,361	9,194,788	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,076,312	387,083	2,689,229	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	116,006,352	8,076,256	107,930,096	0	0	200.00
201.00		Less Observation Beds	3,076,312	387,083	2,689,229	0	0	201.00
202.00		Total (line 200 minus line 201)	112,930,040	7,689,173	105,240,867	0	0	202.00

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

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II | Date/Time Prepared: 5/26/2015 4:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	13,646,561	38,870,840	0.351075	50.00
51.00	05100	RECOVERY ROOM	1,716,635	5,941,687	0.288914	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,021,723	2,641,639	1.522435	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,371,643	94,795,855	0.151606	54.00
59.00	05900	CARDIAC CATHETERIZATION	2,811,583	14,532,696	0.193466	59.00
60.00	06000	LABORATORY	12,077,930	50,244,045	0.240385	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	464,885	19,286,117	0.024105	63.00
64.00	06400	INTRAVENOUS THERAPY	1,202,160	10,487,265	0.114630	64.00
65.00	06500	RESPIRATORY THERAPY	4,403,591	20,584,582	0.213927	65.00
66.00	06600	PHYSICAL THERAPY	1,505,853	3,290,237	0.457673	66.00
69.00	06900	ELECTROCARDIOLOGY	1,524,035	11,089,636	0.137429	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	259,516	1,986,757	0.130623	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,920,525	57,916,022	0.274890	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,676,549	20,088,717	0.631028	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,264,552	34,919,248	0.437139	73.00
74.00	07400	RENAL DIALYSIS	541,567	452,657	1.196418	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	244,583	703,762	0.347537	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	10,276,149	22,743,504	0.451828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,076,312	1,701,560	1.807936	92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (sum of lines 50 thru 199)	116,006,352	412,276,826		200.00
201.00		Less Observation Beds	3,076,312	0		201.00
202.00		Total (line 200 minus line 201)	112,930,040	412,276,826		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | 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	3,969,444	0	3,969,444	42,557	93.27	30.00
31.00	INTENSIVE CARE UNIT	521,724		521,724	9,032	57.76	31.00
40.00	SUBPROVIDER - IPF	740,216	0	740,216	2,678	276.41	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	27,001		27,001	3,310	8.16	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	5,258,385		5,258,385	57,577		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	17,125	1,597,249	30.00
31.00	INTENSIVE CARE UNIT	4,181	241,495	31.00
40.00	SUBPROVIDER - IPF	2,097	579,632	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	23,403	2,418,376	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150009

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

Worksheet D Part II

Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,479,781	38,870,840	0.038069	4,882,221	185,861	50.00
51.00	05100	RECOVERY ROOM	44,726	5,941,687	0.007527	1,022,654	7,698	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	712,005	2,641,639	0.269532	246,693	66,492	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,621,964	94,795,855	0.017110	13,798,763	236,097	54.00
59.00	05900	CARDIAC CATHETERIZATION	348,382	14,532,696	0.023972	3,220,044	77,191	59.00
60.00	06000	LABORATORY	799,523	50,244,045	0.015913	13,632,730	216,938	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	59,484	19,286,117	0.003084	5,649,998	17,425	63.00
64.00	06400	INTRAVENOUS THERAPY	43,066	10,487,265	0.004107	1,954,795	8,028	64.00
65.00	06500	RESPIRATORY THERAPY	112,085	20,584,582	0.005445	9,418,394	51,283	65.00
66.00	06600	PHYSICAL THERAPY	28,277	3,290,237	0.008594	1,833,746	15,759	66.00
69.00	06900	ELECTROCARDIOLOGY	211,200	11,089,636	0.019045	3,084,817	58,750	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,411	1,986,757	0.017320	112,670	1,951	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	425,743	57,916,022	0.007351	17,143,507	126,022	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	269,480	20,088,717	0.013414	7,993,724	107,228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	406,489	34,919,248	0.011641	9,875,582	114,962	73.00
74.00	07400	RENAL DIALYSIS	5,402	452,657	0.011934	211,593	2,525	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	5,794	703,762	0.008233	454	4	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,081,361	22,743,504	0.047546	2,806,714	133,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	387,083	1,701,560	0.227487	75,843	17,253	92.00
200.00		Total (lines 50-199)	8,076,256	412,276,826		96,964,942	1,444,915	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
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)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	42,557	0.00	17,125	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,032	0.00	4,181	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,678	0.00	2,097	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
43.00	04300	NURSERY	3,310	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	57,577		23,403	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | 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	38,870,840	0.000000	0.000000	4,882,221	50.00
51.00	05100	RECOVERY ROOM	0	5,941,687	0.000000	0.000000	1,022,654	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,641,639	0.000000	0.000000	246,693	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	94,795,855	0.000000	0.000000	13,798,763	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,532,696	0.000000	0.000000	3,220,044	59.00
60.00	06000	LABORATORY	0	50,244,045	0.000000	0.000000	13,632,730	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	19,286,117	0.000000	0.000000	5,649,998	63.00
64.00	06400	INTRAVENOUS THERAPY	0	10,487,265	0.000000	0.000000	1,954,795	64.00
65.00	06500	RESPIRATORY THERAPY	0	20,584,582	0.000000	0.000000	9,418,394	65.00
66.00	06600	PHYSICAL THERAPY	0	3,290,237	0.000000	0.000000	1,833,746	66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,089,636	0.000000	0.000000	3,084,817	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,986,757	0.000000	0.000000	112,670	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	57,916,022	0.000000	0.000000	17,143,507	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	20,088,717	0.000000	0.000000	7,993,724	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,919,248	0.000000	0.000000	9,875,582	73.00
74.00	07400	RENAL DIALYSIS	0	452,657	0.000000	0.000000	211,593	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	703,762	0.000000	0.000000	454	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	22,743,504	0.000000	0.000000	2,806,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,701,560	0.000000	0.000000	75,843	92.00
200.00		Total (lines 50-199)	0	412,276,826			96,964,942	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,621,473	0	50.00
51.00	05100	RECOVERY ROOM	0	917,679	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,020	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,108,505	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,268,802	0	59.00
60.00	06000	LABORATORY	0	3,551,629	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,127,273	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,709,506	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,908,514	0	65.00
66.00	06600	PHYSICAL THERAPY	0	308	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,068,679	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	102,069	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,953,873	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,582,438	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,038,234	0	73.00
74.00	07400	RENAL DIALYSIS	0	8,840	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	219,352	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	3,076,659	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	458,028	0	92.00
200.00		Total (lines 50-199)	0	56,732,881	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | Hospital | PPS

		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	0.351075	8,621,473	0	0	3,026,784	50.00
51.00	05100	RECOVERY ROOM	0.288914	917,679	0	0	265,130	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522435	11,020	0	0	16,777	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151606	19,108,505	0	0	2,896,964	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.193466	2,268,802	0	0	438,936	59.00
60.00	06000	LABORATORY	0.240385	3,551,629	0	0	853,758	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.024105	1,127,273	0	0	27,173	63.00
64.00	06400	INTRAVENOUS THERAPY	0.114630	1,709,506	0	0	195,961	64.00
65.00	06500	RESPIRATORY THERAPY	0.213927	1,908,514	0	0	408,283	65.00
66.00	06600	PHYSICAL THERAPY	0.457673	308	0	0	141	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137429	2,068,679	0	0	284,296	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.130623	102,069	0	0	13,333	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274890	5,953,873	354	0	1,636,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.631028	1,582,438	0	0	998,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437139	4,038,234	42,710	0	1,765,270	73.00
74.00	07400	RENAL DIALYSIS	1.196418	8,840	0	0	10,576	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.347537	219,352	0	0	76,233	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.451828	3,076,659	44	0	1,390,121	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.807936	458,028	0	0	828,085	92.00
200.00		Subtotal (see instructions)		56,732,881	43,108	0	15,133,044	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		56,732,881	43,108	0	15,133,044	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,670	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	20	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	18,787	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	18,787	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II | Date/Time Prepared: 5/26/2015 4:18 pm

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	1,479,781	38,870,840	0.038069	3,182	121	50.00
51.00	05100	RECOVERY ROOM	44,726	5,941,687	0.007527	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	712,005	2,641,639	0.269532	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,621,964	94,795,855	0.017110	140,683	2,407	54.00
59.00	05900	CARDIAC CATHETERIZATION	348,382	14,532,696	0.023972	0	0	59.00
60.00	06000	LABORATORY	799,523	50,244,045	0.015913	547,069	8,706	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	59,484	19,286,117	0.003084	64,222	198	63.00
64.00	06400	INTRAVENOUS THERAPY	43,066	10,487,265	0.004107	7,091	29	64.00
65.00	06500	RESPIRATORY THERAPY	112,085	20,584,582	0.005445	43,052	234	65.00
66.00	06600	PHYSICAL THERAPY	28,277	3,290,237	0.008594	43,261	372	66.00
69.00	06900	ELECTROCARDIOLOGY	211,200	11,089,636	0.019045	6,790	129	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,411	1,986,757	0.017320	3,119	54	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	425,743	57,916,022	0.007351	152,394	1,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	269,480	20,088,717	0.013414	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	406,489	34,919,248	0.011641	309,499	3,603	73.00
74.00	07400	RENAL DIALYSIS	5,402	452,657	0.011934	5,780	69	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	5,794	703,762	0.008233	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,081,361	22,743,504	0.047546	48,673	2,314	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,701,560	0.000000	0	0	92.00
200.00		Total (lines 50-199)	7,689,173	412,276,826		1,374,815	19,356	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/26/2015 4:18 pm

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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/26/2015 4:18 pm

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	38,870,840	0.000000	0.000000	3,182	50.00
51.00	05100	RECOVERY ROOM	0	5,941,687	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,641,639	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	94,795,855	0.000000	0.000000	140,683	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,532,696	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	50,244,045	0.000000	0.000000	547,069	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	19,286,117	0.000000	0.000000	64,222	63.00
64.00	06400	INTRAVENOUS THERAPY	0	10,487,265	0.000000	0.000000	7,091	64.00
65.00	06500	RESPIRATORY THERAPY	0	20,584,582	0.000000	0.000000	43,052	65.00
66.00	06600	PHYSICAL THERAPY	0	3,290,237	0.000000	0.000000	43,261	66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,089,636	0.000000	0.000000	6,790	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,986,757	0.000000	0.000000	3,119	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	57,916,022	0.000000	0.000000	152,394	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	20,088,717	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,919,248	0.000000	0.000000	309,499	73.00
74.00	07400	RENAL DIALYSIS	0	452,657	0.000000	0.000000	5,780	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	703,762	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	22,743,504	0.000000	0.000000	48,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,701,560	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	412,276,826			1,374,815	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/26/2015 4:18 pm

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)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	320	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,430	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	2,750	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/26/2015 4:18 pm

Component CCN: 15S009

Title XVIII | Subprovider - IPF | PPS

		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	0.351075	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.288914	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522435	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151606	320	0	0	49	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.193466	0	0	0	0	59.00
60.00	06000	LABORATORY	0.240385	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.024105	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.114630	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.213927	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457673	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137429	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.130623	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274890	2,430	0	0	668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.631028	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437139	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.196418	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.347537	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.451828	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.807936	0	0	0	0	92.00
200.00		Subtotal (see instructions)		2,750	0	0	717	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,750	0	0	717	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/26/2015 4:18 pm

Component CCN: 15S009

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/26/2015 4:18 pm

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	3,969,444	0	3,969,444	42,557	93.27	30.00
31.00	INTENSIVE CARE UNIT	521,724		521,724	9,032	57.76	31.00
40.00	SUBPROVIDER - IPF	740,216	0	740,216	2,678	276.41	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	27,001		27,001	3,310	8.16	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	5,258,385		5,258,385	57,577		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	3,104	289,510	30.00
31.00	INTENSIVE CARE UNIT	730	42,165	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	268	2,187	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	4,102	333,862	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/26/2015 4:18 pm
	Title XIX	Hospital	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,479,781	38,870,840	0.038069	1,505,202	57,302	50.00
51.00	05100	RECOVERY ROOM	44,726	5,941,687	0.007527	133,622	1,006	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	712,005	2,641,639	0.269532	1,231,529	331,936	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,621,964	94,795,855	0.017110	2,390,818	40,907	54.00
59.00	05900	CARDIAC CATHETERIZATION	348,382	14,532,696	0.023972	0	0	59.00
60.00	06000	LABORATORY	799,523	50,244,045	0.015913	4,659,527	74,147	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	59,484	19,286,117	0.003084	129,848	400	63.00
64.00	06400	INTRAVENOUS THERAPY	43,066	10,487,265	0.004107	764,873	3,141	64.00
65.00	06500	RESPIRATORY THERAPY	112,085	20,584,582	0.005445	1,521,057	8,282	65.00
66.00	06600	PHYSICAL THERAPY	28,277	3,290,237	0.008594	117,265	1,008	66.00
69.00	06900	ELECTROCARDIOLOGY	211,200	11,089,636	0.019045	344,467	6,560	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	34,411	1,986,757	0.017320	39,694	688	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	425,743	57,916,022	0.007351	1,240,211	9,117	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	269,480	20,088,717	0.013414	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	406,489	34,919,248	0.011641	2,015,611	23,464	73.00
74.00	07400	RENAL DIALYSIS	5,402	452,657	0.011934	40,566	484	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	5,794	703,762	0.008233	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,081,361	22,743,504	0.047546	891,217	42,374	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	387,083	1,701,560	0.227487	0	0	92.00
200.00		Total (lines 50-199)	8,076,256	412,276,826		17,025,507	600,816	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III | Date/Time Prepared: 5/26/2015 4:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
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)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	42,557	0.00	3,104	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,032	0.00	730	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,678	0.00	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
43.00	04300	NURSERY	3,310	0.00	268	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	57,577		4,102	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/26/2015 4:18 pm

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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/26/2015 4:18 pm

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	38,870,840	0.000000	0.000000	1,505,202	50.00
51.00	05100	RECOVERY ROOM	0	5,941,687	0.000000	0.000000	133,622	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,641,639	0.000000	0.000000	1,231,529	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	94,795,855	0.000000	0.000000	2,390,818	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,532,696	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	50,244,045	0.000000	0.000000	4,659,527	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	19,286,117	0.000000	0.000000	129,848	63.00
64.00	06400	INTRAVENOUS THERAPY	0	10,487,265	0.000000	0.000000	764,873	64.00
65.00	06500	RESPIRATORY THERAPY	0	20,584,582	0.000000	0.000000	1,521,057	65.00
66.00	06600	PHYSICAL THERAPY	0	3,290,237	0.000000	0.000000	117,265	66.00
69.00	06900	ELECTROCARDIOLOGY	0	11,089,636	0.000000	0.000000	344,467	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,986,757	0.000000	0.000000	39,694	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	57,916,022	0.000000	0.000000	1,240,211	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	20,088,717	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,919,248	0.000000	0.000000	2,015,611	73.00
74.00	07400	RENAL DIALYSIS	0	452,657	0.000000	0.000000	40,566	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	703,762	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	22,743,504	0.000000	0.000000	891,217	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,701,560	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	412,276,826			17,025,507	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150009

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

Worksheet D Part IV

Date/Time Prepared: 5/26/2015 4:18 pm

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)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/26/2015 4:18 pm

Title XIX | Hospital | PPS

		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	0.351075	0	1,617	0	0	50.00
51.00	05100	RECOVERY ROOM	0.288914	0	205,675	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522435	0	176,625	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151606	0	3,545,280	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.193466	0	0	0	0	59.00
60.00	06000	LABORATORY	0.240385	0	2,176,437	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.024105	0	24,402	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.114630	0	199,865	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.213927	0	226,591	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457673	0	3,486	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137429	0	146,413	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.130623	0	105,743	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274890	0	411,350	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.631028	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437139	0	447,372	0	0	73.00
74.00	07400	RENAL DIALYSIS	1.196418	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.347537	0	62,748	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.451828	0	2,139,253	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.807936	0	131,306	0	0	92.00
200.00		Subtotal (see instructions)		0	10,004,163	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	10,004,163	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/26/2015 4:18 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	568	0	50.00
51.00	05100	RECOVERY ROOM	59,422	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	268,900	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	537,486	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	523,183	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	588	0	63.00
64.00	06400	INTRAVENOUS THERAPY	22,911	0	64.00
65.00	06500	RESPIRATORY THERAPY	48,474	0	65.00
66.00	06600	PHYSICAL THERAPY	1,595	0	66.00
69.00	06900	ELECTROCARDIOLOGY	20,121	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,812	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,076	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,564	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	21,807	0	76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	966,574	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	237,393	0	92.00
200.00		Subtotal (see instructions)	3,031,474	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,031,474	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | 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)	42,557	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	42,557	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)	38,407	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	17,125	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	31,546,808	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)	31,546,808	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)	31,546,808	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)	741.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	12,694,420	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)	12,694,420	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 4:18 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,574,948	9,032	1,060.11	4,181	4,432,320	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)	27,762,571	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	44,889,311	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,838,744	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,444,915	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,283,659	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	41,605,652	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)	4,150	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	741.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,076,312	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | 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	3,969,444	31,546,808	0.125827	3,076,312	387,083	90.00
91.00	Nursing School cost	0	31,546,808	0.000000	3,076,312	0	91.00
92.00	Allied health cost	0	31,546,808	0.000000	3,076,312	0	92.00
93.00	All other Medical Education	0	31,546,808	0.000000	3,076,312	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/26/2015 4:18 pm

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)	2,678	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,678	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)	2,678	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)	2,097	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,974,917	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)	2,974,917	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)	2,974,917	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)	1,110.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,329,494	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)	2,329,494	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/26/2015 4:18 pm

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)	392,755	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,722,249	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)	579,632	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	19,356	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	598,988	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,123,261	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: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/26/2015 4:18 pm

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	740,216	2,974,917	0.248819	0	0	90.00
91.00	Nursing School cost	0	2,974,917	0.000000	0	0	91.00
92.00	Allied health cost	0	2,974,917	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,974,917	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 4:18 pm
	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)	42,557	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	42,557	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)	38,407	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,104	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)	3,310	15.00
16.00	Nursery days (title V or XIX only)	268	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	31,546,808	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)	31,546,808	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)	31,546,808	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)	741.28	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,300,933	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)	2,300,933	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/26/2015 4:18 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,497,917	3,310	452.54	268	121,281	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,574,948	9,032	1,060.11	730	773,880	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)	6,120,140	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,316,234	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)	333,862	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	600,816	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	934,678	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,381,556	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)	4,150	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	741.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,076,312	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/26/2015 4:18 pm

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	3,969,444	31,546,808	0.125827	3,076,312	387,083	90.00
91.00	Nursing School cost	0	31,546,808	0.000000	3,076,312	0	91.00
92.00	Allied health cost	0	31,546,808	0.000000	3,076,312	0	92.00
93.00	All other Medical Education	0	31,546,808	0.000000	3,076,312	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | 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		10,442,359		30.00
31.00	03100	INTENSIVE CARE UNIT		4,546,012		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.351075	4,882,221	1,714,026	50.00
51.00	05100	RECOVERY ROOM	0.288914	1,022,654	295,459	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522435	246,693	375,574	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151606	13,798,763	2,091,975	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.193466	3,220,044	622,969	59.00
60.00	06000	LABORATORY	0.240385	13,632,730	3,277,104	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.024105	5,649,998	136,193	63.00
64.00	06400	INTRAVENOUS THERAPY	0.114630	1,954,795	224,078	64.00
65.00	06500	RESPIRATORY THERAPY	0.213927	9,418,394	2,014,849	65.00
66.00	06600	PHYSICAL THERAPY	0.457673	1,833,746	839,256	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137429	3,084,817	423,943	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.130623	112,670	14,717	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274890	17,143,507	4,712,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.631028	7,993,724	5,044,264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437139	9,875,582	4,317,002	73.00
74.00	07400	RENAL DIALYSIS	1.196418	211,593	253,154	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.347537	454	158	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.451828	2,806,714	1,268,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.807936	75,843	137,119	92.00
200.00		Total (sum of lines 50-94 and 96-98)		96,964,942	27,762,571	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)		96,964,942		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3
Component CCN: 15S009 | Date/Time Prepared: 5/26/2015 4:18 pm

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		1,208,800		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.351075	3,182	1,117	50.00
51.00	05100	RECOVERY ROOM	0.288914	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522435	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151606	140,683	21,328	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.193466	0	0	59.00
60.00	06000	LABORATORY	0.240385	547,069	131,507	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.024105	64,222	1,548	63.00
64.00	06400	INTRAVENOUS THERAPY	0.114630	7,091	813	64.00
65.00	06500	RESPIRATORY THERAPY	0.213927	43,052	9,210	65.00
66.00	06600	PHYSICAL THERAPY	0.457673	43,261	19,799	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137429	6,790	933	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.130623	3,119	407	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274890	152,394	41,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.631028	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437139	309,499	135,294	73.00
74.00	07400	RENAL DIALYSIS	1.196418	5,780	6,915	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.347537	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.451828	48,673	21,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.807936	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,374,815	392,755	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,374,815		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 4:18 pm
	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		3,026,231		30.00
31.00	03100	INTENSIVE CARE UNIT		716,904		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		461,462		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.351075	1,505,202	528,439	50.00
51.00	05100	RECOVERY ROOM	0.288914	133,622	38,605	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522435	1,231,529	1,874,923	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151606	2,390,818	362,462	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.193466	0	0	59.00
60.00	06000	LABORATORY	0.240385	4,659,527	1,120,080	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.024105	129,848	3,130	63.00
64.00	06400	INTRAVENOUS THERAPY	0.114630	764,873	87,677	64.00
65.00	06500	RESPIRATORY THERAPY	0.213927	1,521,057	325,395	65.00
66.00	06600	PHYSICAL THERAPY	0.457673	117,265	53,669	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137429	344,467	47,340	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.130623	39,694	5,185	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274890	1,240,211	340,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.631028	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437139	2,015,611	881,102	73.00
74.00	07400	RENAL DIALYSIS	1.196418	40,566	48,534	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.347537	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.451828	891,217	402,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.807936	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		17,025,507	6,120,140	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)		17,025,507		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/26/2015 4:18 pm

Title XIX | Subprovider - IPF

		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		60,214		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.351075	21	7	50.00
51.00	05100	RECOVERY ROOM	0.288914	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.522435	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151606	4,876	739	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.193466	0	0	59.00
60.00	06000	LABORATORY	0.240385	31,565	7,588	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.024105	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.114630	636	73	64.00
65.00	06500	RESPIRATORY THERAPY	0.213927	3,207	686	65.00
66.00	06600	PHYSICAL THERAPY	0.457673	2,156	987	66.00
69.00	06900	ELECTROCARDIOLOGY	0.137429	136	19	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.130623	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274890	9,645	2,651	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.631028	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.437139	22,430	9,805	73.00
74.00	07400	RENAL DIALYSIS	1.196418	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	OTHER ANCILLARY SERVICE COST CENTERS	0.347537	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.451828	1,861	841	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.807936	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		76,533	23,396	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)		76,533		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/26/2015 4:18 pm
	Title XVIII	Hospital	PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		25,666,590		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		8,555,531		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		776,883		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		8,202,736		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		157.63		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		4.49		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.86		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		3.63		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.24		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		2.24		12.00
13.00	Total allowable FTE count for the prior year.		1.99		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		2.59		14.00
15.00	Sum of lines 12 through 14 divided by 3.		2.27		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		2.27		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.014401		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.012403		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.012403		21.00
22.00	IME payment adjustment (see instructions)		286,665		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-1.39		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		286,665		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.20		30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.81		31.00
32.00	Sum of lines 30 and 31		26.01		32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.67		33.00
34.00	Disproportionate share adjustment (see instructions)		912,875		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/26/2015 4:18 pm
	Title XVIII	Hospital	PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000367502	0.000334415	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		3,324,563	2,557,499	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,486,590	644,630	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,131,220		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		39,329,764		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		39,329,764		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,931,749		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		83,689		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		3,411		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		42,348,613		59.00
60.00	Primary payer payments		123,826		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		42,224,787		61.00
62.00	Deductibles billed to program beneficiaries		3,753,400		62.00
63.00	Coinsurance billed to program beneficiaries		192,736		63.00
64.00	Allowable bad debts (see instructions)		808,137		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		525,289		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		115,513		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		38,803,940		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-39,868		70.93
70.94	HRR adjustment amount (see instructions)		-157,586		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A | Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		38,606,486		71.00
71.01	Sequestration adjustment (see instructions)		772,130		71.01
72.00	Interim payments		37,170,508		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		663,848		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		218,465		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/26/2015 4:18 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	18,787	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	15,133,044	2.00
3.00	PPS payments	14,048,058	3.00
4.00	Outlier payment (see instructions)	4,569	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)	18,787	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	43,108	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)	43,108	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)	43,108	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	24,321	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)	18,787	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)	14,052,627	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	71	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,107,344	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)	10,963,999	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	26,676	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)	10,990,675	30.00
31.00	Primary payer payments	15,952	31.00
32.00	Subtotal (line 30 minus line 31)	10,974,723	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)	565,338	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	367,470	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	289,681	36.00
37.00	Subtotal (see instructions)	11,342,193	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)	11,342,193	40.00
40.01	Sequestration adjustment (see instructions)	226,844	40.01
41.00	Interim payments	11,019,441	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	95,908	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150009 Component CCN: 15S009	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/26/2015 4:18 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	717	2.00
3.00	PPS payments	53	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	53	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	11	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)	42	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)	42	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	42	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	42	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)	42	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
41.00	Interim payments	42	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-1	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part I Date/Time Prepared: 5/26/2015 4:18 pm
	Title XVIII	Hospital	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		37,098,408		10,953,941	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	07/24/2014	72,100	07/24/2014	65,500	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)		72,100		65,500	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)		37,170,508		11,019,441	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		663,848		95,908	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		37,834,356		11,115,349	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: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/26/2015 4:18 pm

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		1,542,450		42	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	07/24/2014	29,700		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)		29,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,572,150		42	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		1,693		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		1,573,843		41	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: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/26/2015 4:18 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	11,914	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	21,306	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	5,049	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	47,439	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	447,273,181	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,972,701	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)	1,163,879	8.00
9.00	Sequestration adjustment amount (see instructions)	23,278	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,140,601	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,257,790	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)	-117,189	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150009 | Component CCN: 15S009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-3 Part II | Date/Time Prepared: 5/26/2015 4:18 pm

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)	1,689,592	1.00
2.00	Net IPF PPS Outlier Payments	35,326	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)	7.336986	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)	1,724,918	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)	1,724,918	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,724,918	18.00
19.00	Deductibles	121,504	19.00
20.00	Subtotal (line 18 minus line 19)	1,603,414	20.00
21.00	Coinsurance	59,584	21.00
22.00	Subtotal (line 20 minus line 21)	1,543,830	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	95,587	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	62,132	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,391	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,605,962	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)	1,605,962	31.00
31.01	Sequestration adjustment (see instructions)	32,119	31.01
32.00	Interim payments	1,572,150	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)	1,693	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	35,326	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: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2015 4:18 pm
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		3,031,474	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	3,031,474	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		3,031,474	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	0		8.00
9.00	Ancillary service charges	17,025,507	10,004,163	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)	17,025,507	10,004,163	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)	17,025,507	10,004,163	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	17,025,507	6,972,689	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	3,031,474	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	3,031,474	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-4 | Date/Time Prepared: 5/26/2015 4:18 pm

Title XVIII | Hospital | PPS

		1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT		
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.	0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)	4.49	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA	0.86	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)	0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)	0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts	3.63	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)	2.24	6.00
7.00	Enter the lesser of line 5 or line 6	2.24	7.00

		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	2.24	0.00	2.24	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	2.24	0.00	2.24	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	2.24	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.45	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	2.59	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	2.09	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	2.09	0.00		17.00
18.00	Per resident amount	95,408.08	0.00		18.00
19.00	Approved amount for resident costs	199,403	0	199,403	19.00

		1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)	0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)	0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)	0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)	0.00	23.00
24.00	Multiply line 22 time line 23	0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)	199,403	25.00

		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	23,403	5,049		26.00
27.00	Total Inpatient Days (see instructions)	50,117	50,117		27.00
28.00	Ratio of inpatient days to total inpatient days	0.466967	0.100744		28.00
29.00	Program direct GME amount	93,115	20,089		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		2,839		30.00
31.00	Net Program direct GME amount			110,365	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/26/2015 4:18 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	452,657	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	47,611,560	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	123,826	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	47,487,734	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	15,152,548	42.00
43.00	Primary payer payments (see instructions)	15,952	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	15,136,596	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	62,624,330	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.758295	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.241705	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	110,365	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	83,689	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	26,676	50.00

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

Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/26/2015 4:18 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,347,549	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	22,340,135	0	0	0	4.00
5.00	Other receivable	2,328,402	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,037,062	0	0	0	7.00
8.00	Prepaid expenses	1,676,936	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	31,730,084	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,071,554	0	0	0	12.00
13.00	Land improvements	1,458,980	0	0	0	13.00
14.00	Accumulated depreciation	-1,271,922	0	0	0	14.00
15.00	Buildings	87,028,220	0	0	0	15.00
16.00	Accumulated depreciation	-59,728,902	0	0	0	16.00
17.00	Leasehold improvements	1,571,996	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	20,622,577	0	0	0	19.00
20.00	Accumulated depreciation	-18,825,599	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	110,126,678	0	0	0	23.00
24.00	Accumulated depreciation	-77,112,592	0	0	0	24.00
25.00	Minor equipment depreciable	1,627,275	0	0	0	25.00
26.00	Accumulated depreciation	-539,502	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)	71,028,763	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	10,784,809	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	11,111,283	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,896,092	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	124,654,939	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	12,380,311	0	0	0	37.00
38.00	Salaries, wages, and fees payable	297,086	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	71,099	0	0	0	43.00
44.00	Other current liabilities	33,759,234	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	46,507,730	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	47,363,596	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	467,208	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	47,830,804	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	94,338,534	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,316,405				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)	30,316,405	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	124,654,939	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150009

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

Worksheet G-1

Date/Time Prepared:
5/26/2015 4:18 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		39,890,910		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-9,574,505				2.00
3.00	Total (sum of line 1 and line 2)		30,316,405		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)		30,316,405		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,316,405		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			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: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/26/2015 4:18 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	25,833,013		25,833,013	1.00
2.00	SUBPROVIDER - IPF	1,546,975		1,546,975	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	27,379,988		27,379,988	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,245,183		10,245,183	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)	10,245,183		10,245,183	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,625,171		37,625,171	17.00
18.00	Ancillary services	190,863,636	184,573,635	375,437,271	18.00
19.00	Outpatient services	9,087,491	22,315,291	31,402,782	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER	2,074,970	767,082	2,842,052	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	239,651,268	207,656,008	447,307,276	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		166,073,254		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)		166,073,254		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150009 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/26/2015 4:18 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	447,307,276	1.00
2.00	Less contractual allowances and discounts on patients' accounts	285,151,617	2.00
3.00	Net patient revenues (line 1 minus line 2)	162,155,659	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	166,073,254	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,917,595	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	174,518	6.00
7.00	Income from investments	178,811	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	117,209	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	873,262	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	83,498	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	35,280	21.00
22.00	Rental of hospital space	292,626	22.00
23.00	Governmental appropriations	0	23.00
24.00	IDENTIFIED ON TRIAL BALANCE	-7,412,114	24.00
25.00	Total other income (sum of lines 6-24)	-5,656,910	25.00
26.00	Total (line 5 plus line 25)	-9,574,505	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-9,574,505	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150009	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/26/2015 4:18 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	2,705,457	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	66,670	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	129.97	3.00
4.00	Number of interns & residents (see instructions)	2.27	4.00
5.00	Indirect medical education percentage (see instructions)	0.49	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	13,257	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	8.20	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	17.81	8.00
9.00	Sum of lines 7 and 8	26.01	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.41	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	146,365	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	2,931,749	12.00

		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00

		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00