Health Financial Systems | DUKES MEMORIAL HOSPITAL | In Lieu of Form CMS-2552-10

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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S Parts I-III | Date/Time Prepared: 6/1/2015 8:23 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report
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

Date: 6/1/2015 Time: 8:23 am

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 DUKES MEMORIAL HOSPITAL (151318) 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: 6/1/2015 Time: 8:23 am
qp13ujAgSwc4 bhFPbzu7xBvjpf.U0
hp5qXOZi4Y2q0QODeFwxm5bAIcD04h
MkJzOK3QmL0XD5Ob
PI: Date: 6/1/2015 Time: 8:23 am
NMRr.sfzfABLmQ2obzxZ6En1zONOn0
vLQ:DOX3eku8NBF5X14CJX3ddrYLEG
nsEz93BGO1OgIu0T

(signed) [signature]
Officer or Administrator of Provider(s)

Title: CFO

Date: 6-1-15

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	466,938	-701,361	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	114,818	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	581,756	-701,361	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 6/1/2015 8:21 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 275 WEST 12TH STREET	PO Box:			1.00
2.00	City: PERU	State: IN	Zip Code: 46970	County: MIAMI	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	DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DUKES MEMORIAL HOSPITAL SB	15Z318	99915		12/01/2003	N	O	N	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 6/1/2015 8:21 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		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.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 6/1/2015 8:21 am

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

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	12,023	38,555	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

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		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	449008	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: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151318	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 6/1/2015 8:21 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 6/1/2015 8:21 am

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/27/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 6/1/2015 8:21 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LISA	PARRISH	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7554	LISA_PARRISH@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 6/1/2015 8:21 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/27/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 6/1/2015 8:21 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	57,168.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	57,168.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	11,256.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	68,424.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 6/1/2015 8:21 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,476	137	2,382			1.00
2.00	HMO and other (see instructions)	204	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	329	0	344			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)	1,805	137	2,726			7.00
8.00	INTENSIVE CARE UNIT	283	0	469			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		0	439			13.00
14.00	Total (see instructions)	2,088	137	3,634	0.00	199.51	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	199.51	27.00
28.00	Observation Bed Days		0	672			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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 6/1/2015 8:21 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	501	40	1,047	1.00
2.00	HMO and other (see instructions)			60	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	501	40	1,047	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151318	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 6/1/2015 8:21 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.217977	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,450,667	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?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,877,395	5.00
6.00	Medicaid charges	23,297,817	6.00
7.00	Medicaid cost (line 1 times line 6)	5,078,388	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)	750,326	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)	791,431	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	3,781,624	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	824,307	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)	32,876	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)	783,202	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	347,568	0	347,568	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	75,762	0	75,762	21.00
22.00	Partial payment by patients approved for charity care	2,603	0	2,603	22.00
23.00	Cost of charity care (line 21 minus line 22)	73,159	0	73,159	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,088,480	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	504,001	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,584,479	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	999,311	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,072,470	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,855,672	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		691,831	691,831	427,927	1,119,758	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,535,089	1,535,089	338,112	1,873,201	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	94,588	59,410	153,998	1,606,918	1,760,916	4.00
5.01	00570	ADMITTING	0	0	0	6,434,969	6,434,969	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	1,980,523	11,809,048	13,789,571	-8,660,193	5,129,378	5.02
7.00	00700	OPERATION OF PLANT	230,075	1,097,567	1,327,642	5,876	1,333,518	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	92,922	92,922	0	92,922	8.00
9.00	00900	HOUSEKEEPING	219,874	66,961	286,835	0	286,835	9.00
10.00	01000	DIETARY	193,603	161,816	355,419	-222,815	132,604	10.00
11.00	01100	CAFETERIA	0	0	0	221,880	221,880	11.00
13.00	01300	NURSING ADMINISTRATION	305,944	59,529	365,473	-119,895	245,578	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,203	308,583	383,786	-197,093	186,693	14.00
15.00	01500	PHARMACY	385,207	970,901	1,356,108	-809,239	546,869	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,811	191,721	331,532	75,038	406,570	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,434,242	707,599	2,141,841	-140,345	2,001,496	30.00
31.00	03100	INTENSIVE CARE UNIT	324,413	44,341	368,754	-1,069	367,685	31.00
43.00	04300	NURSERY	0	0	0	127,933	127,933	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	427,342	1,193,022	1,620,364	-410,263	1,210,101	50.00
51.00	05100	RECOVERY ROOM	253,099	36,844	289,943	-992	288,951	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	494,847	236,553	731,400	543,089	1,274,489	54.00
54.01	05401	ULTRASOUND	105,922	15,377	121,299	-121,299	0	54.01
56.00	05600	RADIOISOTOPE	81,086	106,293	187,379	-187,379	0	56.00
57.00	05700	CT SCAN	56,061	124,761	180,822	-180,822	0	57.00
58.00	05800	MRI	43,841	92,071	135,912	-135,912	0	58.00
60.00	06000	LABORATORY	611,675	776,520	1,388,195	-41,089	1,347,106	60.00
65.00	06500	RESPIRATORY THERAPY	300,854	56,577	357,431	-1,146	356,285	65.00
66.00	06600	PHYSICAL THERAPY	2,898	555,554	558,452	-1,046	557,406	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	192,001	192,001	0	192,001	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,615	25,615	0	25,615	68.00
69.00	06900	ELECTROCARDIOLOGY	113,024	22,151	135,175	-935	134,240	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	182,926	182,926	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	371,791	371,791	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	744,205	744,205	73.00
76.00	03610	SLEEP LAB	72,895	16,843	89,738	-1,269	88,469	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	243,468	50,934	294,402	-2,910	291,492	90.00
91.00	09100	EMERGENCY	2,645,741	646,841	3,292,582	-3,061	3,289,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	194,615	138,310	332,925	0	332,925	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,030,851	22,083,585	33,114,436	-158,108	32,956,328	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	15,623	16,347	-16,347	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	174,455	174,455	194.01
194.02	07952	SENIOR CIRCLE	0	-2,316	-2,316	0	-2,316	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	11,031,575	22,096,892	33,128,467	0	33,128,467	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	328,467	1,448,225		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-276,493	1,596,708		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,403	1,758,513		4.00
5.01	00570	ADMITTING	-5,158,903	1,276,066		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	-153,511	4,975,867		5.02
7.00	00700	OPERATION OF PLANT	2,540	1,336,058		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-18,111	74,811		8.00
9.00	00900	HOUSEKEEPING	0	286,835		9.00
10.00	01000	DIETARY	0	132,604		10.00
11.00	01100	CAFETERIA	-60,153	161,727		11.00
13.00	01300	NURSING ADMINISTRATION	-1,643	243,935		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	186,693		14.00
15.00	01500	PHARMACY	0	546,869		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,566	392,004		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-399,100	1,602,396		30.00
31.00	03100	INTENSIVE CARE UNIT	0	367,685		31.00
43.00	04300	NURSERY	0	127,933		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-449,448	760,653		50.00
51.00	05100	RECOVERY ROOM	0	288,951		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,274,489		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	-72,000	1,275,106		60.00
65.00	06500	RESPIRATORY THERAPY	0	356,285		65.00
66.00	06600	PHYSICAL THERAPY	0	557,406		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	192,001		67.00
68.00	06800	SPEECH PATHOLOGY	0	25,615		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,882	131,358		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	182,926		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	371,791		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	744,205		73.00
76.00	03610	SLEEP LAB	-4,275	84,194		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	291,492		90.00
91.00	09100	EMERGENCY	0	3,289,521		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,666	331,259		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,284,147	26,672,181		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NRCC	0	0		194.00
194.01	07951	MARKETING	-10,800	163,655		194.01
194.02	07952	SENIOR CIRCLE	2,316	0		194.02
194.03	07953	FREE MEALS	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-6,292,631	26,835,836		200.00

RECLASSIFICATIONS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 6/1/2015 8:21 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,607,910	1.00
	0		0	1,607,910	
	B - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	31,933	1.00
	0		0	31,933	
	C - LEASE AND RENT				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	310,080	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
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
	0		0	310,080	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	67,532	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	360,395	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	28,032	3.00
	0		0	455,959	
	E - MARKETING				
1.00	MARKETING	194.01	53,648	120,807	1.00
	0		53,648	120,807	
	F - CNO				
1.00	NURSING ADMINISTRATION	13.00	222,612	0	1.00
	0		222,612	0	
	G - CHARGABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	150,993	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	371,791	2.00
	0		0	522,784	
	H - DRUGS AND IVS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	744,205	1.00
	0		0	744,205	
	I - NURSERY				
1.00	NURSERY	43.00	107,306	20,627	1.00
	0		107,306	20,627	
	J - QUALITY AND CASE MANAGEMENT				
1.00	ADMINISTRATIVE AND GENERAL	5.02	219,621	42,488	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	71,788	5,546	2.00
	0		291,409	48,034	
	K - FRAGMENTED A&G				
1.00	ADMITTING	5.01	647,303	5,787,666	1.00
	0		647,303	5,787,666	
	L - RADIOLOGY				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	286,910	338,096	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		286,910	338,096	
	M - DIETATY				
1.00	CAFETERIA	11.00	120,862	101,018	1.00
	0		120,862	101,018	
	N - POB UTILITIES				
1.00	OPERATION OF PLANT	7.00	724	15,623	1.00
	0		724	15,623	
500.00	Grand Total: Increases		1,730,774	10,104,742	500.00

RECLASSIFICATIONS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 6/1/2015 8:21 am

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - EMPLOYEE BENEFITS					
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	1,607,910	0	1.00
	0		0	1,607,910		
	B - OXYGEN					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	31,933	0	1.00
	0		0	31,933		
	C - LEASE AND RENT					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	992	10	1.00
2.00	ADMINISTRATIVE AND GENERAL	5.02	0	26,397	0	2.00
3.00	OPERATION OF PLANT	7.00	0	10,471	0	3.00
4.00	DIETARY	10.00	0	935	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	3,064	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,708	0	6.00
7.00	PHARMACY	15.00	0	65,034	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,296	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	12,412	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,069	0	10.00
11.00	OPERATING ROOM	50.00	0	50,931	0	11.00
12.00	RECOVERY ROOM	51.00	0	992	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	81,917	0	13.00
14.00	MRI	58.00	0	406	0	14.00
15.00	LABORATORY	60.00	0	41,089	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,146	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	1,046	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	935	0	18.00
19.00	SLEEP LAB	76.00	0	1,269	0	19.00
20.00	CLINIC	90.00	0	2,910	0	20.00
21.00	EMERGENCY	91.00	0	3,061	0	21.00
	0		0	310,080		
	D - OTHER CAPITAL COSTS					
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	455,959	12	1.00
2.00		0.00	0	0	13	2.00
3.00		0.00	0	0	12	3.00
	0		0	455,959		
	E - MARKETING					
1.00	ADMINISTRATIVE AND GENERAL	5.02	53,648	120,807	0	1.00
	0		53,648	120,807		
	F - CNO					
1.00	ADMINISTRATIVE AND GENERAL	5.02	222,612	0	0	1.00
	0		222,612	0		
	G - CHARGABLE MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	163,452	0	1.00
2.00	OPERATING ROOM	50.00	0	359,332	0	2.00
	0		0	522,784		
	H - DRUGS AND IVS					
1.00	PHARMACY	15.00	0	744,205	0	1.00
	0		0	744,205		
	I - NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	107,306	20,627	0	1.00
	0		107,306	20,627		
	J - QUALITY AND CASE MANAGEMENT					
1.00	NURSING ADMINISTRATION	13.00	291,409	48,034	0	1.00
2.00		0.00	0	0	0	2.00
	0		291,409	48,034		
	K - FRAGMENTED A&G					
1.00	ADMINISTRATIVE AND GENERAL	5.02	647,303	5,787,666	0	1.00
	0		647,303	5,787,666		
	L - RADIOLOGY					
1.00	ULTRASOUND	54.01	105,922	15,377	0	1.00
2.00	RADIOISOTOPE	56.00	81,086	106,293	0	2.00
3.00	CT SCAN	57.00	56,061	124,761	0	3.00
4.00	MRI	58.00	43,841	91,665	0	4.00
	0		286,910	338,096		
	M - DIETATY					
1.00	DIETARY	10.00	120,862	101,018	0	1.00
	0		120,862	101,018		
	N - POB UTILITIES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	724	15,623	0	1.00
	0		724	15,623		
500.00	Grand Total: Decreases		1,730,774	10,104,742		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I Date/Time Prepared: 6/1/2015 8:21 am

		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	193,225	0	0	0	0	1.00
2.00	Land Improvements	936,429	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,988,109	0	0	0	0	3.00
4.00	Building Improvements	15,543,251	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	2,294,361	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,955,375	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	47,955,375	0	0	0	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	193,225	0	1.00
2.00	Land Improvements	936,429	0	2.00
3.00	Buildings and Fixtures	28,988,109	0	3.00
4.00	Building Improvements	15,543,251	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	2,294,361	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,955,375	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	47,955,375	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 6/1/2015 8:21 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	691,831	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,478,058	57,031	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,169,889	57,031	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	691,831	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,535,089	2.00
3.00	Total (sum of lines 1-2)	0	2,226,920	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 6/1/2015 8:21 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	30,117,763	0	30,117,763	0.628037	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,837,612	0	17,837,612	0.371963	0	2.00
3.00	Total (sum of lines 1-2)	47,955,375	0	47,955,375	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,022,822	-11,410	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,192,073	367,300	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,214,895	355,890	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,316	67,532	360,571	1,394	1,448,225	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,069	28,032	0	8,234	1,596,708	2.00
3.00	Total (sum of lines 1-2)	8,385	95,564	360,571	9,628	3,044,933	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 6/1/2015 8:21 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-952,865			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	57,727			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-60,153	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-14,566	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	-2,142	ADMINISTRATIVE AND GENERAL	5.02	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 - CAP REL COSTS-BLDG & FIXT	A	330,991	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	101,289	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-378,050	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	RENTAL INCOME	B	-11,410	CAP REL COSTS-BLDG & FIXT	1.00	10	33.00
35.00	TRAINING REVENUE	B	-1,643	NURSING ADMINISTRATION	13.00	0	35.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 6/1/2015 8:21 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
36.00	FITNESS REVENUE	B	-390	ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	OTHER MISC REVENUE - HOSPITAL	B	-17,906	ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	HOSPITAL BAD DEBT	A	-5,088,480	ADMITTING	5.01	0	38.00
40.00	PATIENT PHONES WAGE COST	A	-11,214	ADMINISTRATIVE AND GENERAL	5.02	0	40.00
41.00	PATIENT PHONES BENEFITS COST	A	-2,403	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00	PATIENT PHONES EXPENSE	A	-3,005	ADMINISTRATIVE AND GENERAL	5.02	0	42.00
43.00	PATIENT PHONES DEPRECIATION COST	A	-6,205	CAP REL COSTS-MVBLE EQUIP	2.00	9	43.00
44.00	PATIENT TV SERVICE COST	A	-12,615	ADMINISTRATIVE AND GENERAL	5.02	0	44.00
44.01	PATIENT TV DEPRECIATION	A	-3,019	CAP REL COSTS-MVBLE EQUIP	2.00	9	44.01
45.00	MARKETING EXPENSE	A	-112,353	ADMINISTRATIVE AND GENERAL	5.02	0	45.00
45.01	PENALTIES	A	-400	ADMINISTRATIVE AND GENERAL	5.02	0	45.01
45.02	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-2,615	ADMINISTRATIVE AND GENERAL	5.02	0	45.02
45.03	CHARITABLE CONTRIBUTIONS	A	-20,923	ADMINISTRATIVE AND GENERAL	5.02	0	45.03
45.04	BOARD AND STAFF RELATIONS	A	-22,486	ADMINISTRATIVE AND GENERAL	5.02	0	45.04
45.05	PHYSICIAN RECRUITING	A	-47,705	ADMINISTRATIVE AND GENERAL	5.02	0	45.05
45.06	POB UTILITIES	A	2,540	OPERATION OF PLANT	7.00	0	45.06
45.07	POB PROPERTY TAX	A	176	CAP REL COSTS-BLDG & FIXT	1.00	13	45.07
45.08	OTHER NON-ALLOWABLE COST	A	-675	ADMINISTRATIVE AND GENERAL	5.02	0	45.08
45.09	NON-ALLOWABLE INTEREST	A	-34	ADMINISTRATIVE AND GENERAL	5.02	0	45.09
45.10	LEGAL FEES	A	-14,413	ADMINISTRATIVE AND GENERAL	5.02	0	45.10
45.11	ELIMINATE NEGATIVE COST CENTER	A	2,316	SENIOR CIRCLE	194.02	0	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,292,631				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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 6/1/2015 8:21 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	7,316	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	1,069	0	2.00
3.00	5.01	ADMITTING	PASI OPERATING COSTS	103,859	0	3.00
3.01	1.00	CAP REL COSTS-BLDG & FIXT	PRE-ACQ LGCY CAP COSTS - BLD	1,394	0	3.01
3.02	2.00	CAP REL COSTS-MVBLE EQUIP	PRE-ACQ LGCY CAP COSTS - MVB	8,234	0	3.02
3.03	5.02	ADMINISTRATIVE AND GENERAL	PRE-ACQ PERIOD NONCAPITAL AL	85,549	0	3.03
3.04	5.02	ADMINISTRATIVE AND GENERAL	PASI OPERATING COST	114,510	0	3.04
4.00	5.02	ADMINISTRATIVE AND GENERAL	NEW CAPITAL BLDG AND FIXTURE	5,911	0	4.00
4.01	5.02	ADMINISTRATIVE AND GENERAL	NEW CAPITAL MOVEABLE EQUIPME	39,240	0	4.01
4.02	5.02	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	566,116	0	4.02
4.03	5.02	ADMINISTRATIVE AND GENERAL	MALPRACTICE	50,578	92,510	4.03
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	57,220	57,031	4.05
4.06	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICE	102,478	120,589	4.06
4.07	5.02	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	283,279	4.07
4.08	5.02	ADMINISTRATIVE AND GENERAL	401K FEES	0	1,047	4.08
4.09	5.02	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	20,349	4.09
4.10	5.02	ADMINISTRATIVE AND GENERAL	MIS FEES	0	169,412	4.10
4.11	5.02	ADMINISTRATIVE AND GENERAL	MANAGED CARE	0	10,859	4.11
4.12	5.02	ADMINISTRATIVE AND GENERAL	CASE MANAGEMENT	0	65,515	4.12
4.13	5.02	ADMINISTRATIVE AND GENERAL	PURCHASE & ANCILLARY	0	3,768	4.13
4.14	5.02	ADMINISTRATIVE AND GENERAL	EMERGENCY ROOM	0	39,191	4.14
4.15	5.02	ADMINISTRATIVE AND GENERAL	PPSI FEES	0	19,677	4.15
4.16	5.02	ADMINISTRATIVE AND GENERAL	COMPLIANCE/HIM/CCA FEES	0	17,438	4.16
4.17	194.01	MARKETING	SENIOR CIRCLE	0	10,800	4.17
4.18	5.01	ADMITTING	PASI COLLECTION FEES	0	147,513	4.18
4.19	5.01	ADMITTING	PASI EBOS	0	3,937	4.19
4.20	5.01	ADMITTING	PASI LIEN UNIT COLLECTION FE	0	22,832	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,143,474	1,085,747	5.00

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

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

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

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

6.00	B		0.00	COMMUNITY HEALTH SYTEMS	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00	B		0.00	HOSPITAL LAUNDRY SERVICE	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151318	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 6/1/2015 8:21 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	7,316	11		1.00
2.00	1,069	11		2.00
3.00	103,859	0		3.00
3.01	1,394	14		3.01
3.02	8,234	14		3.02
3.03	85,549	0		3.03
3.04	114,510	0		3.04
4.00	5,911	0		4.00
4.01	39,240	0		4.01
4.02	566,116	0		4.02
4.03	-41,932	0		4.03
4.05	189	10		4.05
4.06	-18,111	0		4.06
4.07	-283,279	0		4.07
4.08	-1,047	0		4.08
4.09	-20,349	0		4.09
4.10	-169,412	0		4.10
4.11	-10,859	0		4.11
4.12	-65,515	0		4.12
4.13	-3,768	0		4.13
4.14	-39,191	0		4.14
4.15	-19,677	0		4.15
4.16	-17,438	0		4.16
4.17	-10,800	0		4.17
4.18	-147,513	0		4.18
4.19	-3,937	0		4.19
4.20	-22,832	0		4.20
5.00	57,727			5.00

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

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

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

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

6.00	HOSPITAL MANAGEMENT		6.00
7.00	DEBT COLLECTION		7.00
8.00	LAUNDRY SERVICE		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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 6/1/2015 8:21 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.02	ADMINISTRATIVE AND GENERAL	31,719	23,494	8,225	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	399,100	399,100	0	0	0	2.00
3.00	50.00	OPERATING ROOM	449,448	449,448	0	0	0	3.00
4.00	60.00	LABORATORY	72,000	72,000	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	2,882	2,882	0	0	0	5.00
6.00	76.00	SLEEP LAB	4,275	4,275	0	0	0	6.00
7.00	91.00	EMERGENCY	1,674,252	0	1,674,252	0	0	7.00
8.00	95.00	AMBULANCE SERVICES	1,666	1,666	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,635,342	952,865	1,682,477		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	ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.00	SLEEP LAB	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	ADMINISTRATIVE AND GENERAL	0	0	0	23,494		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	399,100		2.00
3.00	50.00	OPERATING ROOM	0	0	0	449,448		3.00
4.00	60.00	LABORATORY	0	0	0	72,000		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,882		5.00
6.00	76.00	SLEEP LAB	0	0	0	4,275		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	95.00	AMBULANCE SERVICES	0	0	0	1,666		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	952,865		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/1/2015 8:21 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					5.19	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	4,043.24	3,992.70	3,833.66	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.05	57.04	38.02	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.03	38.03	28.52			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					307,488	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					227,744	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					535,232	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					145,756	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					680,988	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					680,988	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.05	57.04	38.02	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	680,988		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	680,988		63.00
64.00	Total cost of outside supplier services (from your records)	547,323		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		5.19	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,732.07	2.26	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.08	54.06	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.04	36.04	27.03			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	196,928	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	122	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	197,050	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	197,050	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	197,050	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.08	54.06	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		197,050	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		197,050	63.00
64.00	Total cost of outside supplier services (from your records)		189,861	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

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Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					5.19	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	368.35	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.26	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.63	34.63	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					25,512	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					25,512	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					25,512	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.26	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					54,023	22.00
23.00	Total salary equivalency (see instructions)					54,023	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.26	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	54,023	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	54,023	63.00
64.00	Total cost of outside supplier services (from your records)	25,616	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,448,225	1,448,225				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,596,708		1,596,708			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,758,513	10,220	11,314	1,780,047		4.00
5.01	00570	ADMITTING	1,276,066	15,550	17,214	105,352	1,414,182	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	4,975,867	73,732	81,625	207,770	0	5.02
7.00	00700	OPERATION OF PLANT	1,336,058	428,561	474,440	37,564	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,811	16,826	18,627	0	0	8.00
9.00	00900	HOUSEKEEPING	286,835	13,930	15,421	35,786	0	9.00
10.00	01000	DIETARY	132,604	35,169	38,933	11,839	0	10.00
11.00	01100	CAFETERIA	161,727	22,588	25,006	19,671	0	11.00
13.00	01300	NURSING ADMINISTRATION	243,935	6,569	7,272	38,597	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	186,693	34,472	38,162	12,240	0	14.00
15.00	01500	PHARMACY	546,869	16,092	17,815	62,694	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	392,004	29,084	32,197	34,439	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,602,396	241,407	267,250	215,965	74,479	30.00
31.00	03100	INTENSIVE CARE UNIT	367,685	27,977	30,971	52,800	10,384	31.00
43.00	04300	NURSERY	127,933	5,535	6,128	17,465	4,866	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	760,653	110,909	122,782	69,552	160,725	50.00
51.00	05100	RECOVERY ROOM	288,951	7,984	8,839	41,193	28,726	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,274,489	78,006	86,356	127,235	282,663	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,275,106	31,188	34,526	99,553	211,964	60.00
65.00	06500	RESPIRATORY THERAPY	356,285	13,387	14,820	48,965	16,082	65.00
66.00	06600	PHYSICAL THERAPY	557,406	18,372	20,339	472	39,460	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,001	6,012	6,655	0	13,062	67.00
68.00	06800	SPEECH PATHOLOGY	25,615	242	268	0	877	68.00
69.00	06900	ELECTROCARDIOLOGY	131,358	9,084	10,056	18,395	48,614	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	182,926	0	0	0	50,743	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	371,791	0	0	0	28,792	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	744,205	0	0	0	163,411	73.00
76.00	03610	SLEEP LAB	84,194	12,969	14,358	11,864	9,990	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	291,492	8,431	9,334	39,626	1,826	90.00
91.00	09100	EMERGENCY	3,289,521	53,724	59,476	430,604	204,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	331,259	21,635	23,951	31,675	62,754	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,672,181	1,349,655	1,494,135	1,771,316	1,414,182	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,916	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	92,654	102,573	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	163,655	0	0	8,731	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	26,835,836	1,448,225	1,596,708	1,780,047	1,414,182	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	5,338,994	5,338,994				5.02
7.00	00700	OPERATION OF PLANT	2,276,623	565,427	2,842,050			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	110,264	27,385	51,968	189,617		8.00
9.00	00900	HOUSEKEEPING	351,972	87,416	43,024	0	482,412	9.00
10.00	01000	DIETARY	218,545	54,278	108,623	0	19,075	10.00
11.00	01100	CAFETERIA	228,992	56,873	69,766	0	12,252	11.00
13.00	01300	NURSING ADMINISTRATION	296,373	73,608	20,289	0	3,563	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	271,567	67,447	106,472	0	18,698	14.00
15.00	01500	PHARMACY	643,470	159,813	49,704	0	8,728	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	487,724	121,132	89,829	0	15,775	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,401,497	596,441	745,622	75,274	130,941	30.00
31.00	03100	INTENSIVE CARE UNIT	489,817	121,652	86,410	4,616	15,174	31.00
43.00	04300	NURSERY	161,927	40,217	17,096	0	3,002	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,224,621	304,149	342,559	31,465	60,157	50.00
51.00	05100	RECOVERY ROOM	375,693	93,308	24,659	0	4,330	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,848,749	459,159	240,932	21,426	42,310	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,652,337	410,378	96,328	310	16,916	60.00
65.00	06500	RESPIRATORY THERAPY	449,539	111,648	41,348	0	7,261	65.00
66.00	06600	PHYSICAL THERAPY	636,049	157,970	56,746	0	9,965	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,730	54,076	18,568	0	3,261	67.00
68.00	06800	SPEECH PATHOLOGY	27,002	6,706	747	0	131	68.00
69.00	06900	ELECTROCARDIOLOGY	217,507	54,020	28,056	0	4,927	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	233,669	58,035	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	400,583	99,490	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	907,616	225,417	0	0	0	73.00
76.00	03610	SLEEP LAB	133,375	33,125	40,057	4,748	7,034	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	350,709	87,103	26,041	0	4,573	90.00
91.00	09100	EMERGENCY	4,038,089	1,002,904	165,935	51,778	29,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	471,274	117,047	66,822	0	11,735	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,462,307	5,246,224	2,537,601	189,617	428,948	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,916	1,469	18,274	0	3,209	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	195,227	48,487	286,175	0	50,255	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	172,386	42,814	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	26,835,836	5,338,994	2,842,050	189,617	482,412	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	400,521					10.00
11.00	01100	CAFETERIA	0	367,883				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,361	397,194			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,352	0	470,536		14.00
15.00	01500	PHARMACY	0	13,021	0	11,260	885,996	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,509	0	625	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	285,453	67,648	103,651	31,501	0	30.00
31.00	03100	INTENSIVE CARE UNIT	37,150	14,186	25,341	4,448	0	31.00
43.00	04300	NURSERY	0	4,737	8,382	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	20,856	33,381	74,982	0	50.00
51.00	05100	RECOVERY ROOM	0	11,539	19,770	3,530	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,709	0	22,787	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	41,235	0	116,801	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,795	0	8,387	0	65.00
66.00	06600	PHYSICAL THERAPY	0	238	0	1,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	613	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,161	0	1,128	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	46,220	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	106,503	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	885,996	73.00
76.00	03610	SLEEP LAB	0	3,467	0	1,400	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,031	0	8,082	0	90.00
91.00	09100	EMERGENCY	0	81,173	206,669	18,825	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,430	0	11,214	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	322,603	365,448	397,194	470,054	885,996	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	208	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,435	0	274	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	77,918	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	400,521	367,883	397,194	470,536	885,996	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	730,594					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,474	4,476,502	0	4,476,502		30.00
31.00	03100	INTENSIVE CARE UNIT	5,364	804,158	0	804,158		31.00
43.00	04300	NURSERY	2,514	237,875	0	237,875		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	83,026	2,175,196	0	2,175,196		50.00
51.00	05100	RECOVERY ROOM	14,839	547,668	0	547,668		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	146,083	2,818,155	0	2,818,155		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	109,495	2,443,800	0	2,443,800		60.00
65.00	06500	RESPIRATORY THERAPY	8,307	641,285	0	641,285		65.00
66.00	06600	PHYSICAL THERAPY	20,384	883,100	0	883,100		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,747	300,995	0	300,995		67.00
68.00	06800	SPEECH PATHOLOGY	453	35,039	0	35,039		68.00
69.00	06900	ELECTROCARDIOLOGY	25,113	335,912	0	335,912		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,212	364,136	0	364,136		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,873	621,449	0	621,449		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,414	2,103,443	0	2,103,443		73.00
76.00	03610	SLEEP LAB	5,161	228,367	0	228,367		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	943	487,482	0	487,482		90.00
91.00	09100	EMERGENCY	105,775	5,700,288	0	5,700,288		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	32,417	725,939	0	725,939		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	730,594	25,930,789	0	25,930,789		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,868	0	28,868		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	580,352	0	580,352		192.00
194.00	07950	OTHER NRCC	0	0	0	0		194.00
194.01	07951	MARKETING	0	217,909	0	217,909		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	FREE MEALS	0	77,918	0	77,918		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	730,594	26,835,836	0	26,835,836		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,220	11,314	21,534	21,534	4.00
5.01	00570	ADMITTING	0	15,550	17,214	32,764	1,275	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	73,732	81,625	155,357	2,514	5.02
7.00	00700	OPERATION OF PLANT	0	428,561	474,440	903,001	454	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,826	18,627	35,453	0	8.00
9.00	00900	HOUSEKEEPING	0	13,930	15,421	29,351	433	9.00
10.00	01000	DIETARY	0	35,169	38,933	74,102	143	10.00
11.00	01100	CAFETERIA	0	22,588	25,006	47,594	238	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,569	7,272	13,841	467	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,472	38,162	72,634	148	14.00
15.00	01500	PHARMACY	0	16,092	17,815	33,907	758	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,084	32,197	61,281	417	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	241,407	267,250	508,657	2,613	30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,977	30,971	58,948	639	31.00
43.00	04300	NURSERY	0	5,535	6,128	11,663	211	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	110,909	122,782	233,691	841	50.00
51.00	05100	RECOVERY ROOM	0	7,984	8,839	16,823	498	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	78,006	86,356	164,362	1,539	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	31,188	34,526	65,714	1,204	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,387	14,820	28,207	592	65.00
66.00	06600	PHYSICAL THERAPY	0	18,372	20,339	38,711	6	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,012	6,655	12,667	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	242	268	510	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,084	10,056	19,140	223	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	12,969	14,358	27,327	144	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,431	9,334	17,765	479	90.00
91.00	09100	EMERGENCY	0	53,724	59,476	113,200	5,209	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	21,635	23,951	45,586	383	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,349,655	1,494,135	2,843,790	21,428	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,916	0	5,916	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	92,654	102,573	195,227	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	106	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,448,225	1,596,708	3,044,933	21,534	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	ADMITTING	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	34,039					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	0	157,871				5.02
7.00	00700	OPERATION OF PLANT	0	16,720	920,175			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	810	16,826	53,089		8.00
9.00	00900	HOUSEKEEPING	0	2,585	13,930	0	46,299	9.00
10.00	01000	DIETARY	0	1,605	35,169	0	1,831	10.00
11.00	01100	CAFETERIA	0	1,682	22,588	0	1,176	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,177	6,569	0	342	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,994	34,473	0	1,794	14.00
15.00	01500	PHARMACY	0	4,726	16,093	0	838	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,582	29,084	0	1,514	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,792	17,637	241,411	21,075	12,566	30.00
31.00	03100	INTENSIVE CARE UNIT	250	3,597	27,977	1,292	1,456	31.00
43.00	04300	NURSERY	117	1,189	5,535	0	288	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,867	8,994	110,911	8,810	5,773	50.00
51.00	05100	RECOVERY ROOM	691	2,759	7,984	0	416	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,817	13,577	78,007	5,999	4,061	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	5,099	12,135	31,188	87	1,624	60.00
65.00	06500	RESPIRATORY THERAPY	387	3,301	13,387	0	697	65.00
66.00	06600	PHYSICAL THERAPY	949	4,671	18,373	0	956	66.00
67.00	06700	OCCUPATIONAL THERAPY	314	1,599	6,012	0	313	67.00
68.00	06800	SPEECH PATHOLOGY	21	198	242	0	13	68.00
69.00	06900	ELECTROCARDIOLOGY	1,170	1,597	9,084	0	473	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,221	1,716	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	693	2,942	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,931	6,666	0	0	0	73.00
76.00	03610	SLEEP LAB	240	980	12,969	1,329	675	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44	2,576	8,431	0	439	90.00
91.00	09100	EMERGENCY	4,926	29,652	53,725	14,497	2,797	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,510	3,461	21,635	0	1,126	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,039	155,128	821,603	53,089	41,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43	5,917	0	308	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,434	92,655	0	4,823	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,266	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	34,039	157,871	920,175	53,089	46,299	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	112,850					10.00
11.00	01100	CAFETERIA	0	73,278				11.00
13.00	01300	NURSING ADMINISTRATION	0	670	24,066			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,265	0	112,308		14.00
15.00	01500	PHARMACY	0	2,594	0	2,688	61,604	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,089	0	149	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,429	13,475	6,280	7,519	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,467	2,826	1,535	1,062	0	31.00
43.00	04300	NURSERY	0	944	508	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,154	2,023	17,897	0	50.00
51.00	05100	RECOVERY ROOM	0	2,299	1,198	843	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,312	0	5,439	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	8,213	0	27,877	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,947	0	2,002	0	65.00
66.00	06600	PHYSICAL THERAPY	0	47	0	417	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	146	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,028	0	269	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,032	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,420	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	61,604	73.00
76.00	03610	SLEEP LAB	0	691	0	334	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,998	0	1,929	0	90.00
91.00	09100	EMERGENCY	0	16,168	12,522	4,493	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,073	0	2,677	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	90,896	72,793	24,066	112,193	61,604	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	50	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	485	0	65	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	21,954	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	112,850	73,278	24,066	112,308	61,604	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	99,116					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,219	918,673	0	918,673		30.00
31.00	03100	INTENSIVE CARE UNIT	728	110,777	0	110,777		31.00
43.00	04300	NURSERY	341	20,796	0	20,796		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,262	408,223	0	408,223		50.00
51.00	05100	RECOVERY ROOM	2,013	35,524	0	35,524		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,831	306,944	0	306,944		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	14,852	167,993	0	167,993		60.00
65.00	06500	RESPIRATORY THERAPY	1,127	52,647	0	52,647		65.00
66.00	06600	PHYSICAL THERAPY	2,765	66,895	0	66,895		66.00
67.00	06700	OCCUPATIONAL THERAPY	915	21,966	0	21,966		67.00
68.00	06800	SPEECH PATHOLOGY	61	1,045	0	1,045		68.00
69.00	06900	ELECTROCARDIOLOGY	3,406	36,390	0	36,390		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,556	17,525	0	17,525		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,017	31,072	0	31,072		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,450	83,651	0	83,651		73.00
76.00	03610	SLEEP LAB	700	45,389	0	45,389		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	128	33,789	0	33,789		90.00
91.00	09100	EMERGENCY	14,348	271,537	0	271,537		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,397	83,848	0	83,848		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	99,116	2,714,684	0	2,714,684		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,184	0	12,184		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	294,189	0	294,189		192.00
194.00	07950	OTHER NRCC	0	0	0	0		194.00
194.01	07951	MARKETING	0	1,922	0	1,922		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	FREE MEALS	0	21,954	0	21,954		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	99,116	3,044,933	0	3,044,933		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	197,538					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		196,731				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,394	1,394	10,936,987			4.00
5.01	00570	ADMITTING	2,121	2,121	647,303	118,960,997		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	10,057	10,057	1,276,581	0	-5,338,994	5.02
7.00	00700	OPERATION OF PLANT	58,456	58,456	230,799	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,295	2,295	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,900	1,900	219,874	0	0	9.00
10.00	01000	DIETARY	4,797	4,797	72,741	0	0	10.00
11.00	01100	CAFETERIA	3,081	3,081	120,862	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	896	896	237,147	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,702	4,702	75,203	0	0	14.00
15.00	01500	PHARMACY	2,195	2,195	385,207	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,967	3,967	211,599	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,928	32,928	1,326,936	6,265,061	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,816	3,816	324,413	873,478	0	31.00
43.00	04300	NURSERY	755	755	107,306	409,346	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,128	15,128	427,342	13,519,931	0	50.00
51.00	05100	RECOVERY ROOM	1,089	1,089	253,099	2,416,426	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,640	10,640	781,757	23,779,370	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,254	4,254	611,675	17,830,089	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,826	1,826	300,854	1,352,768	0	65.00
66.00	06600	PHYSICAL THERAPY	2,506	2,506	2,898	3,319,322	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	820	820	0	1,098,727	0	67.00
68.00	06800	SPEECH PATHOLOGY	33	33	0	73,735	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,239	1,239	113,024	4,089,357	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,268,384	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,421,944	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,745,889	0	73.00
76.00	03610	SLEEP LAB	1,769	1,769	72,895	840,343	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,150	1,150	243,468	153,601	0	90.00
91.00	09100	EMERGENCY	7,328	7,328	2,645,741	17,224,429	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,951	2,951	194,615	5,278,797	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	184,093	184,093	10,883,339	118,960,997	-5,338,994	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	807	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,638	12,638	0	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	53,648	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,448,225	1,596,708	1,780,047	1,414,182		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.331374	8.116199	0.162755	0.011888		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			21,534	34,039		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001969	0.000286		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL	21,496,842					5.02
7.00	00700	OPERATION OF PLANT	2,276,623	125,510				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	110,264	2,295	165,644			8.00
9.00	00900	HOUSEKEEPING	351,972	1,900	0	121,315		9.00
10.00	01000	DIETARY	218,545	4,797	0	4,797	15,169	10.00
11.00	01100	CAFETERIA	228,992	3,081	0	3,081	0	11.00
13.00	01300	NURSING ADMINISTRATION	296,373	896	0	896	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	271,567	4,702	0	4,702	0	14.00
15.00	01500	PHARMACY	643,470	2,195	0	2,195	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	487,724	3,967	0	3,967	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,401,497	32,928	65,757	32,928	10,811	30.00
31.00	03100	INTENSIVE CARE UNIT	489,817	3,816	4,032	3,816	1,407	31.00
43.00	04300	NURSERY	161,927	755	0	755	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,224,621	15,128	27,487	15,128	0	50.00
51.00	05100	RECOVERY ROOM	375,693	1,089	0	1,089	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,848,749	10,640	18,717	10,640	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,652,337	4,254	271	4,254	0	60.00
65.00	06500	RESPIRATORY THERAPY	449,539	1,826	0	1,826	0	65.00
66.00	06600	PHYSICAL THERAPY	636,049	2,506	0	2,506	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,730	820	0	820	0	67.00
68.00	06800	SPEECH PATHOLOGY	27,002	33	0	33	0	68.00
69.00	06900	ELECTROCARDIOLOGY	217,507	1,239	0	1,239	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	233,669	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	400,583	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	907,616	0	0	0	0	73.00
76.00	03610	SLEEP LAB	133,375	1,769	4,148	1,769	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	350,709	1,150	0	1,150	0	90.00
91.00	09100	EMERGENCY	4,038,089	7,328	45,232	7,328	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	471,274	2,951	0	2,951	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,123,313	112,065	165,644	107,870	12,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,916	807	0	807	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	195,227	12,638	0	12,638	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	172,386	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	2,951	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,338,994	2,842,050	189,617	482,412	400,521	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.248362	22.644012	1.144726	3.976524	26.403916	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	157,871	920,175	53,089	46,299	112,850	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007344	7.331488	0.320501	0.381643	7.439515	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 6/1/2015 8:21 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ U)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL						5.02
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	13,900					11.00
13.00	01300	NURSING ADMINISTRATION	127	5,084,837				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	240	0	1,642,597			14.00
15.00	01500	PHARMACY	492	0	39,308	751,583		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	586	0	2,183	0	118,960,997	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,556	1,326,936	109,968	0	6,265,061	30.00
31.00	03100	INTENSIVE CARE UNIT	536	324,413	15,528	0	873,478	31.00
43.00	04300	NURSERY	179	107,306	0	0	409,346	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	788	427,342	261,755	0	13,519,931	50.00
51.00	05100	RECOVERY ROOM	436	253,099	12,324	0	2,416,426	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,387	0	79,547	0	23,779,370	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,558	0	407,740	0	17,830,089	60.00
65.00	06500	RESPIRATORY THERAPY	559	0	29,277	0	1,352,768	65.00
66.00	06600	PHYSICAL THERAPY	9	0	6,101	0	3,319,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,140	0	1,098,727	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	73,735	68.00
69.00	06900	ELECTROCARDIOLOGY	195	0	3,938	0	4,089,357	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	161,349	0	4,268,384	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	371,791	0	2,421,944	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	751,583	13,745,889	73.00
76.00	03610	SLEEP LAB	131	0	4,889	0	840,343	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	379	0	28,214	0	153,601	90.00
91.00	09100	EMERGENCY	3,067	2,645,741	65,717	0	17,224,429	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	583	0	39,148	0	5,278,797	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,808	5,084,837	1,640,917	751,583	118,960,997	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	725	0	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	92	0	955	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	FREE MEALS	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	367,883	397,194	470,536	885,996	730,594	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.466403	0.078113	0.286459	1.178840	0.006141	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	73,278	24,066	112,308	61,604	99,116	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.271799	0.004733	0.068372	0.081966	0.000833	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,476,502		4,476,502	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	804,158		804,158	0	0	31.00
43.00	04300	NURSERY	237,875		237,875	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,175,196		2,175,196	0	0	50.00
51.00	05100	RECOVERY ROOM	547,668		547,668	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,818,155		2,818,155	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,443,800		2,443,800	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	641,285	0	641,285	0	0	65.00
66.00	06600	PHYSICAL THERAPY	883,100	0	883,100	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,995	0	300,995	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,039	0	35,039	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	335,912		335,912	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	364,136		364,136	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	621,449		621,449	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,103,443		2,103,443	0	0	73.00
76.00	03610	SLEEP LAB	228,367		228,367	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	487,482		487,482	0	0	90.00
91.00	09100	EMERGENCY	5,700,288		5,700,288	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	885,286		885,286		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	725,939		725,939	0	0	95.00
200.00		Subtotal (see instructions)	26,816,075	0	26,816,075	0	0	200.00
201.00		Less Observation Beds	885,286		885,286		0	201.00
202.00		Total (see instructions)	25,930,789	0	25,930,789	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,739,719		4,739,719			30.00
31.00	03100	INTENSIVE CARE UNIT	873,478		873,478			31.00
43.00	04300	NURSERY	409,346		409,346			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,676,804	9,843,127	13,519,931	0.160888	0.000000	50.00
51.00	05100	RECOVERY ROOM	565,901	1,850,525	2,416,426	0.226644	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,120,306	20,659,064	23,779,370	0.118513	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	4,190,476	13,639,613	17,830,089	0.137060	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,096,467	256,301	1,352,768	0.474054	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	474,949	2,844,373	3,319,322	0.266048	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	439,125	659,602	1,098,727	0.273949	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	29,476	44,259	73,735	0.475202	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,065,308	3,024,049	4,089,357	0.082143	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,913,733	2,354,651	4,268,384	0.085310	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,466,279	955,665	2,421,944	0.256591	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,636,272	7,109,617	13,745,889	0.153023	0.000000	73.00
76.00	03610	SLEEP LAB	7,823	832,520	840,343	0.271755	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,448	143,153	153,601	3.173690	0.000000	90.00
91.00	09100	EMERGENCY	1,771,503	15,452,926	17,224,429	0.330942	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	175,718	1,349,624	1,525,342	0.580385	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,278,797	5,278,797	0.137520	0.000000	95.00
200.00		Subtotal (see instructions)	32,663,131	86,297,866	118,960,997			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,663,131	86,297,866	118,960,997			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03610	SLEEP LAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,476,502		4,476,502	0	4,476,502	30.00
31.00	03100	INTENSIVE CARE UNIT	804,158		804,158	0	804,158	31.00
43.00	04300	NURSERY	237,875		237,875	0	237,875	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,175,196		2,175,196	0	2,175,196	50.00
51.00	05100	RECOVERY ROOM	547,668		547,668	0	547,668	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,818,155		2,818,155	0	2,818,155	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,443,800		2,443,800	0	2,443,800	60.00
65.00	06500	RESPIRATORY THERAPY	641,285	0	641,285	0	641,285	65.00
66.00	06600	PHYSICAL THERAPY	883,100	0	883,100	0	883,100	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,995	0	300,995	0	300,995	67.00
68.00	06800	SPEECH PATHOLOGY	35,039	0	35,039	0	35,039	68.00
69.00	06900	ELECTROCARDIOLOGY	335,912		335,912	0	335,912	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	364,136		364,136	0	364,136	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	621,449		621,449	0	621,449	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,103,443		2,103,443	0	2,103,443	73.00
76.00	03610	SLEEP LAB	228,367		228,367	0	228,367	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	487,482		487,482	0	487,482	90.00
91.00	09100	EMERGENCY	5,700,288		5,700,288	0	5,700,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	885,286		885,286		885,286	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	725,939		725,939	0	725,939	95.00
200.00		Subtotal (see instructions)	26,816,075	0	26,816,075	0	26,816,075	200.00
201.00		Less Observation Beds	885,286		885,286		885,286	201.00
202.00		Total (see instructions)	25,930,789	0	25,930,789	0	25,930,789	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,739,719		4,739,719			30.00
31.00	03100	INTENSIVE CARE UNIT	873,478		873,478			31.00
43.00	04300	NURSERY	409,346		409,346			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,676,804	9,843,127	13,519,931	0.160888	0.000000	50.00
51.00	05100	RECOVERY ROOM	565,901	1,850,525	2,416,426	0.226644	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,120,306	20,659,064	23,779,370	0.118513	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	4,190,476	13,639,613	17,830,089	0.137060	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,096,467	256,301	1,352,768	0.474054	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	474,949	2,844,373	3,319,322	0.266048	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	439,125	659,602	1,098,727	0.273949	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	29,476	44,259	73,735	0.475202	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,065,308	3,024,049	4,089,357	0.082143	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,913,733	2,354,651	4,268,384	0.085310	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,466,279	955,665	2,421,944	0.256591	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,636,272	7,109,617	13,745,889	0.153023	0.000000	73.00
76.00	03610	SLEEP LAB	7,823	832,520	840,343	0.271755	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,448	143,153	153,601	3.173690	0.000000	90.00
91.00	09100	EMERGENCY	1,771,503	15,452,926	17,224,429	0.330942	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	175,718	1,349,624	1,525,342	0.580385	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,278,797	5,278,797	0.137520	0.000000	95.00
200.00		Subtotal (see instructions)	32,663,131	86,297,866	118,960,997			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,663,131	86,297,866	118,960,997			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.160888		50.00
51.00	05100	RECOVERY ROOM	0.226644		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118513		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.137060		60.00
65.00	06500	RESPIRATORY THERAPY	0.474054		65.00
66.00	06600	PHYSICAL THERAPY	0.266048		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273949		67.00
68.00	06800	SPEECH PATHOLOGY	0.475202		68.00
69.00	06900	ELECTROCARDIOLOGY	0.082143		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.085310		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256591		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153023		73.00
76.00	03610	SLEEP LAB	0.271755		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	3.173690		90.00
91.00	09100	EMERGENCY	0.330942		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580385		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.137520		95.00
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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II | Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,175,196	408,223	1,766,973	0	0	50.00
51.00	05100	RECOVERY ROOM	547,668	35,524	512,144	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,818,155	306,944	2,511,211	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,443,800	167,993	2,275,807	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	641,285	52,647	588,638	0	0	65.00
66.00	06600	PHYSICAL THERAPY	883,100	66,895	816,205	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,995	21,966	279,029	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,039	1,045	33,994	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	335,912	36,390	299,522	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	364,136	17,525	346,611	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	621,449	31,072	590,377	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,103,443	83,651	2,019,792	0	0	73.00
76.00	03610	SLEEP LAB	228,367	45,389	182,978	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	487,482	33,789	453,693	0	0	90.00
91.00	09100	EMERGENCY	5,700,288	271,537	5,428,751	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	885,286	202,144	683,142	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	725,939	83,848	642,091	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	21,297,540	1,866,582	19,430,958	0	0	200.00
201.00		Less Observation Beds	885,286	202,144	683,142	0	0	201.00
202.00		Total (line 200 minus line 201)	20,412,254	1,664,438	18,747,816	0	0	202.00

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

Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,175,196	13,519,931	0.160888		50.00
51.00	05100	RECOVERY ROOM	547,668	2,416,426	0.226644		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,818,155	23,779,370	0.118513		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	2,443,800	17,830,089	0.137060		60.00
65.00	06500	RESPIRATORY THERAPY	641,285	1,352,768	0.474054		65.00
66.00	06600	PHYSICAL THERAPY	883,100	3,319,322	0.266048		66.00
67.00	06700	OCCUPATIONAL THERAPY	300,995	1,098,727	0.273949		67.00
68.00	06800	SPEECH PATHOLOGY	35,039	73,735	0.475202		68.00
69.00	06900	ELECTROCARDIOLOGY	335,912	4,089,357	0.082143		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	364,136	4,268,384	0.085310		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	621,449	2,421,944	0.256591		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,103,443	13,745,889	0.153023		73.00
76.00	03610	SLEEP LAB	228,367	840,343	0.271755		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	487,482	153,601	3.173690		90.00
91.00	09100	EMERGENCY	5,700,288	17,224,429	0.330942		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	885,286	1,525,342	0.580385		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	725,939	5,278,797	0.137520		95.00
200.00		Subtotal (sum of lines 50 thru 199)	21,297,540	112,938,454			200.00
201.00		Less Observation Beds	885,286	0			201.00
202.00		Total (line 200 minus line 201)	20,412,254	112,938,454			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	408,223	13,519,931	0.030194	829,326	25,041	50.00
51.00	05100	RECOVERY ROOM	35,524	2,416,426	0.014701	137,326	2,019	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	306,944	23,779,370	0.012908	1,249,170	16,124	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	167,993	17,830,089	0.009422	1,772,978	16,705	60.00
65.00	06500	RESPIRATORY THERAPY	52,647	1,352,768	0.038918	739,843	28,793	65.00
66.00	06600	PHYSICAL THERAPY	66,895	3,319,322	0.020153	162,016	3,265	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,966	1,098,727	0.019992	180,404	3,607	67.00
68.00	06800	SPEECH PATHOLOGY	1,045	73,735	0.014172	23,462	333	68.00
69.00	06900	ELECTROCARDIOLOGY	36,390	4,089,357	0.008899	595,136	5,296	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,525	4,268,384	0.004106	767,707	3,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,072	2,421,944	0.012829	846,397	10,858	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,651	13,745,889	0.006086	3,373,954	20,534	73.00
76.00	03610	SLEEP LAB	45,389	840,343	0.054012	4,470	241	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,789	153,601	0.219979	202	44	90.00
91.00	09100	EMERGENCY	271,537	17,224,429	0.015765	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,144	1,525,342	0.132524	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,782,734	107,659,657		10,682,391	136,012	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,519,931	0.000000	0.000000	829,326	50.00
51.00	05100	RECOVERY ROOM	0	2,416,426	0.000000	0.000000	137,326	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,779,370	0.000000	0.000000	1,249,170	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	17,830,089	0.000000	0.000000	1,772,978	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,352,768	0.000000	0.000000	739,843	65.00
66.00	06600	PHYSICAL THERAPY	0	3,319,322	0.000000	0.000000	162,016	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,098,727	0.000000	0.000000	180,404	67.00
68.00	06800	SPEECH PATHOLOGY	0	73,735	0.000000	0.000000	23,462	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,089,357	0.000000	0.000000	595,136	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,268,384	0.000000	0.000000	767,707	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,421,944	0.000000	0.000000	846,397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,745,889	0.000000	0.000000	3,373,954	73.00
76.00	03610	SLEEP LAB	0	840,343	0.000000	0.000000	4,470	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	153,601	0.000000	0.000000	202	90.00
91.00	09100	EMERGENCY	0	17,224,429	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,525,342	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	107,659,657			10,682,391	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03610	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.160888	0	2,144,260	0	0	50.00
51.00	05100	RECOVERY ROOM	0.226644	0	447,461	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118513	0	6,685,946	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.137060	0	4,763,878	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.474054	0	128,280	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.266048	0	1,023,241	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273949	0	147,074	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.475202	0	16,571	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.082143	0	1,309,475	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.085310	0	320,356	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256591	0	181,159	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153023	0	3,066,182	0	0	73.00
76.00	03610	SLEEP LAB	0.271755	0	234,588	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.173690	0	49,098	0	0	90.00
91.00	09100	EMERGENCY	0.330942	0	4,266,032	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580385	0	445,936	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.137520		0			95.00
200.00		Subtotal (see instructions)		0	25,229,537	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	25,229,537	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	344,986	0		50.00
51.00	05100	RECOVERY ROOM	101,414	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	792,372	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	652,937	0		60.00
65.00	06500	RESPIRATORY THERAPY	60,812	0		65.00
66.00	06600	PHYSICAL THERAPY	272,231	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	40,291	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,875	0		68.00
69.00	06900	ELECTROCARDIOLOGY	107,564	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,330	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,484	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	469,196	0		73.00
76.00	03610	SLEEP LAB	63,750	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	155,822	0		90.00
91.00	09100	EMERGENCY	1,411,809	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	258,815	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,813,688	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,813,688	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151318 | Component CCN: 15Z318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.160888	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.226644	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118513	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.137060	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.474054	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.266048	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273949	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.475202	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.082143	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.085310	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256591	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153023	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.271755	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.173690	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.330942	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580385	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.137520		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151318 | Component CCN: 15Z318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03610	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	918,673	0	918,673	3,054	300.81	30.00
31.00	INTENSIVE CARE UNIT	110,777		110,777	469	236.20	31.00
43.00	NURSERY	20,796		20,796	439	47.37	43.00
200.00	Total (lines 30-199)	1,050,246		1,050,246	3,962		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	137	41,211	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	137	41,211	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	408,223	13,519,931	0.030194	198,958	6,007	50.00
51.00	05100	RECOVERY ROOM	35,524	2,416,426	0.014701	29,939	440	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	306,944	23,779,370	0.012908	113,826	1,469	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	167,993	17,830,089	0.009422	141,273	1,331	60.00
65.00	06500	RESPIRATORY THERAPY	52,647	1,352,768	0.038918	16,461	641	65.00
66.00	06600	PHYSICAL THERAPY	66,895	3,319,322	0.020153	5,613	113	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,966	1,098,727	0.019992	1,419	28	67.00
68.00	06800	SPEECH PATHOLOGY	1,045	73,735	0.014172	672	10	68.00
69.00	06900	ELECTROCARDIOLOGY	36,390	4,089,357	0.008899	31,788	283	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,525	4,268,384	0.004106	53,238	219	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,072	2,421,944	0.012829	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,651	13,745,889	0.006086	175,605	1,069	73.00
76.00	03610	SLEEP LAB	45,389	840,343	0.054012	1,118	60	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,789	153,601	0.219979	101	22	90.00
91.00	09100	EMERGENCY	271,537	17,224,429	0.015765	69,828	1,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,144	1,525,342	0.132524	5,628	746	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,782,734	107,659,657		845,467	13,539	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
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	3,054	0.00	137	0		30.00
31.00	03100	INTENSIVE CARE UNIT	469	0.00	0	0		31.00
43.00	04300	NURSERY	439	0.00	0	0		43.00
200.00		Total (lines 30-199)	3,962		137	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,519,931	0.000000	0.000000	198,958	50.00
51.00	05100	RECOVERY ROOM	0	2,416,426	0.000000	0.000000	29,939	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,779,370	0.000000	0.000000	113,826	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	17,830,089	0.000000	0.000000	141,273	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,352,768	0.000000	0.000000	16,461	65.00
66.00	06600	PHYSICAL THERAPY	0	3,319,322	0.000000	0.000000	5,613	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,098,727	0.000000	0.000000	1,419	67.00
68.00	06800	SPEECH PATHOLOGY	0	73,735	0.000000	0.000000	672	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,089,357	0.000000	0.000000	31,788	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,268,384	0.000000	0.000000	53,238	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,421,944	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,745,889	0.000000	0.000000	175,605	73.00
76.00	03610	SLEEP LAB	0	840,343	0.000000	0.000000	1,118	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	153,601	0.000000	0.000000	101	90.00
91.00	09100	EMERGENCY	0	17,224,429	0.000000	0.000000	69,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,525,342	0.000000	0.000000	5,628	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	107,659,657			845,467	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03610	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 6/1/2015 8:21 am

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	0.160888	0	384,013	0	0	50.00
51.00	05100	RECOVERY ROOM	0.226644	0	65,862	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118513	0	1,424,709	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.137060	0	947,117	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.474054	0	23,542	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.266048	0	124,417	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273949	0	63,165	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.475202	0	7,005	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.082143	0	168,277	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.085310	0	48,873	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256591	0	38,645	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153023	0	423,626	0	0	73.00
76.00	03610	SLEEP LAB	0.271755	0	80,354	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3.173690	0	9,618	0	0	90.00
91.00	09100	EMERGENCY	0.330942	0	1,377,175	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580385	0	131,309	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.137520	0	422,517			95.00
200.00		Subtotal (see instructions)		0	5,740,224	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	5,740,224	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	61,783	0		50.00
51.00	05100	RECOVERY ROOM	14,927	0		51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,847	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	129,812	0		60.00
65.00	06500	RESPIRATORY THERAPY	11,160	0		65.00
66.00	06600	PHYSICAL THERAPY	33,101	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	17,304	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,329	0		68.00
69.00	06900	ELECTROCARDIOLOGY	13,823	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,169	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,916	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,825	0		73.00
76.00	03610	SLEEP LAB	21,837	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	30,525	0		90.00
91.00	09100	EMERGENCY	455,765	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	76,210	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	58,105			95.00
200.00		Subtotal (see instructions)	1,175,438	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,175,438	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,398	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,054	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.	469	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,913	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	344	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)	1,476	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)	329	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,476,502	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)	453,182	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,023,320	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	6,022,543	28.00
29.00	Private room charges (excluding swing-bed charges)	873,478	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	5,149,065	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.668043	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,862.43	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	2,691.62	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)	4,023,320	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)	1,317.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,944,468	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,944,468	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	804,158	469	1,714.62	283	485,237	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)	1,859,706	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,289,411	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	433,421	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)	433,421	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)	672	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,317.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	885,286	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	918,673	4,023,320	0.228337	885,286	202,144	90.00
91.00	Nursing School cost	0	4,023,320	0.000000	885,286	0	91.00
92.00	Allied health cost	0	4,023,320	0.000000	885,286	0	92.00
93.00	All other Medical Education	0	4,023,320	0.000000	885,286	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151318	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 6/1/2015 8:21 am
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,398	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,054	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)	2,382	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)	137	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)	439	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,476,502	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)	4,476,502	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)	4,476,502	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)	1,465.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	200,812	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)	200,812	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 6/1/2015 8:21 am

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)	237,875	439	541.86	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	804,158	469	1,714.62	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)	142,677	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	343,489	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)	41,211	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	13,539	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	54,750	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	288,739	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)	672	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,465.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	985,004	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	918,673	4,476,502	0.205221	985,004	202,144	90.00
91.00	Nursing School cost	0	4,476,502	0.000000	985,004	0	91.00
92.00	Allied health cost	0	4,476,502	0.000000	985,004	0	92.00
93.00	All other Medical Education	0	4,476,502	0.000000	985,004	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,222,631		30.00
31.00	03100	INTENSIVE CARE UNIT		634,412		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160888	829,326	133,429	50.00
51.00	05100	RECOVERY ROOM	0.226644	137,326	31,124	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118513	1,249,170	148,043	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.137060	1,772,978	243,004	60.00
65.00	06500	RESPIRATORY THERAPY	0.474054	739,843	350,726	65.00
66.00	06600	PHYSICAL THERAPY	0.266048	162,016	43,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273949	180,404	49,421	67.00
68.00	06800	SPEECH PATHOLOGY	0.475202	23,462	11,149	68.00
69.00	06900	ELECTROCARDIOLOGY	0.082143	595,136	48,886	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.085310	767,707	65,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256591	846,397	217,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153023	3,373,954	516,293	73.00
76.00	03610	SLEEP LAB	0.271755	4,470	1,215	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.173690	202	641	90.00
91.00	09100	EMERGENCY	0.330942	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580385	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		10,682,391	1,859,706	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)		10,682,391		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151318 | Component CCN: 15Z318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160888	0	0	50.00
51.00	05100	RECOVERY ROOM	0.226644	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118513	8,994	1,066	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.137060	48,938	6,707	60.00
65.00	06500	RESPIRATORY THERAPY	0.474054	37,318	17,691	65.00
66.00	06600	PHYSICAL THERAPY	0.266048	217,904	57,973	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273949	198,704	54,435	67.00
68.00	06800	SPEECH PATHOLOGY	0.475202	2,002	951	68.00
69.00	06900	ELECTROCARDIOLOGY	0.082143	561	46	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.085310	13,995	1,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256591	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153023	287,604	44,010	73.00
76.00	03610	SLEEP LAB	0.271755	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.173690	0	0	90.00
91.00	09100	EMERGENCY	0.330942	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580385	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		816,020	184,073	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)		816,020		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 6/1/2015 8:21 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		120,824		30.00
31.00	03100	INTENSIVE CARE UNIT		24,750		31.00
43.00	04300	NURSERY		48,958		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160888	198,958	32,010	50.00
51.00	05100	RECOVERY ROOM	0.226644	29,939	6,785	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.118513	113,826	13,490	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.137060	141,273	19,363	60.00
65.00	06500	RESPIRATORY THERAPY	0.474054	16,461	7,803	65.00
66.00	06600	PHYSICAL THERAPY	0.266048	5,613	1,493	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273949	1,419	389	67.00
68.00	06800	SPEECH PATHOLOGY	0.475202	672	319	68.00
69.00	06900	ELECTROCARDIOLOGY	0.082143	31,788	2,611	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.085310	53,238	4,542	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.256591	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.153023	175,605	26,872	73.00
76.00	03610	SLEEP LAB	0.271755	1,118	304	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3.173690	101	321	90.00
91.00	09100	EMERGENCY	0.330942	69,828	23,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.580385	5,628	3,266	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		845,467	142,677	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)		845,467		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151318	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 6/1/2015 8:21 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,813,688	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,813,688	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)	4,861,825	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	25,636	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,117,669	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)	718,520	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)	718,520	30.00
31.00	Primary payer payments	1,158	31.00
32.00	Subtotal (line 30 minus line 31)	717,362	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)	628,164	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	477,405	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	575,104	36.00
37.00	Subtotal (see instructions)	1,194,767	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)	1,194,767	40.00
40.01	Sequestration adjustment (see instructions)	23,895	40.01
41.00	Interim payments	1,872,233	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-701,361	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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 6/1/2015 8:21 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,956,683		1,872,233	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/15/2014	422,800		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)		422,800		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)		3,379,483		1,872,233	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		466,938		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		701,361	6.02
7.00	Total Medicare program liability (see instructions)		3,846,421		1,170,872	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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 6/1/2015 8:21 am

Component CCN: 15Z318 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		495,662		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		495,662		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		114,818		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		610,480		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151318	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 6/1/2015 8:21 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,047	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,759	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	204	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,851	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	118,960,997	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	347,568	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151318 Component CCN: 15Z318	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 6/1/2015 8:21 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	437,755	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	185,914	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	329	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	623,669	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	623,669	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	623,669	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,064	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	622,605	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	514	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	334	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	622,939	0	19.00
19.01	Sequestration adjustment (see instructions)	12,459	0	19.01
20.00	Interim payments	495,662	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	114,818	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151318	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 6/1/2015 8:21 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,289,411	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	4,289,411	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,332,305	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,332,305	19.00
20.00	Deductibles (exclude professional component)	432,736	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,899,569	22.00
23.00	Coinsurance	912	23.00
24.00	Subtotal (line 22 minus line 23)	3,898,657	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	34,555	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	26,262	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,016	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,924,919	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,924,919	30.00
30.01	Sequestration adjustment (see instructions)	78,498	30.01
31.00	Interim payments	3,379,483	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	466,938	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	599,740	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 6/1/2015 8:21 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-109,618	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,144,359	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,417,364	0	0	0	6.00
7.00	Inventory	880,965	0	0	0	7.00
8.00	Prepaid expenses	291,150	0	0	0	8.00
9.00	Other current assets	194,273	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)	8,983,765	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	500,000	0	0	0	12.00
13.00	Land improvements	219,345	0	0	0	13.00
14.00	Accumulated depreciation	-67,643	0	0	0	14.00
15.00	Buildings	10,457,432	0	0	0	15.00
16.00	Accumulated depreciation	-2,194,387	0	0	0	16.00
17.00	Leasehold improvements	5,796,884	0	0	0	17.00
18.00	Accumulated depreciation	-1,210,807	0	0	0	18.00
19.00	Fixed equipment	1,283,703	0	0	0	19.00
20.00	Accumulated depreciation	-425,873	0	0	0	20.00
21.00	Automobiles and trucks	514,173	0	0	0	21.00
22.00	Accumulated depreciation	-265,559	0	0	0	22.00
23.00	Major movable equipment	5,664,571	0	0	0	23.00
24.00	Accumulated depreciation	-3,799,554	0	0	0	24.00
25.00	Minor equipment depreciable	2,712,067	0	0	0	25.00
26.00	Accumulated depreciation	-1,566,916	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)	17,617,436	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,234,806	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,234,806	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	27,836,007	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,071,301	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,159,684	0	0	0	38.00
39.00	Payroll taxes payable	98,304	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	-5,313,268	0	0	0	43.00
44.00	Other current liabilities	629,176	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-2,354,803	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-2,354,803	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,190,810				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)	30,190,810	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,836,007	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 6/1/2015 8:21 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		25,132,363		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,058,447				2.00
3.00	Total (sum of line 1 and line 2)		30,190,810		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)		30,190,810		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)		30,190,810		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: 151318 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/1/2015 8:21 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,149,065		5,149,065	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,149,065		5,149,065	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	873,478		873,478	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)	873,478		873,478	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,022,543		6,022,543	17.00
18.00	Ancillary services	24,682,919	63,240,846	87,923,765	18.00
19.00	Outpatient services	1,957,669	23,057,020	25,014,689	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PHYSICIAN	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	32,663,131	86,297,866	118,960,997	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,128,467		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)		33,128,467		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151318	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 6/1/2015 8:21 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	118,960,997	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,906,570	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,054,427	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,128,467	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,925,960	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	132,487	24.00
25.00	Total other income (sum of lines 6-24)	132,487	25.00
26.00	Total (line 5 plus line 25)	5,058,447	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,058,447	29.00