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: 151312	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/28/2015 3:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2015 Time: 3:19 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH WHITE HOSPITAL (151312) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

CHIEF FINANCIAL OFFICER
Title

Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	618,506	-463,894	-4,600	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	252,655	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	871,161	-463,894	-4,600	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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 5:51 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 720 SOUTH SIXTH STREET	PO Box:			1.00
2.00	City: MONTICELLO	State: IN	Zip Code: 47960	County: WHITE	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	IU HEALTH WHITE HOSPITAL	151312	99915	1	07/01/1966	N	O	O	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	IU HEALTH WHITE HOSPITAL	15Z312	99915		02/16/1990	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	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N	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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 5:51 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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.				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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 5:51 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 5:51 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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.	Y	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	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	N	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	45,190	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		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	15H059	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: INDIANA UNIVERSITY HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 340 WEST 10TH STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	233,504	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: 151312	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 5:51 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		Y	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 5:51 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	03/26/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	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.	Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/24/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 5:51 pm

		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.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	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.	RHONDA	UTTER	41.00
42.00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVERSITY HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.962.1093	RUTTER@IUHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 5:51 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/24/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		GOVERNMENT PROGRAMS 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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2015 5:51 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	24	8,760	50,664.00	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)		24	8,760	50,664.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	1	365	2,592.00	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	53,256.00	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	101.00				0	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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 5:51 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,342	147	2,111			1.00
2.00	HMO and other (see instructions)	127	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	631	0	636			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	57			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,973	147	2,804			7.00
8.00	INTENSIVE CARE UNIT	52	0	108			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		59	114			13.00
14.00	Total (see instructions)	2,025	206	3,026	0.00	149.46	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	0	0	0	0.00	0.00	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	149.46	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 5:51 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	441	80	877	1.00
2.00	HMO and other (see instructions)			30	76		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	441	80	877	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	0.00					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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/27/2015 5:51 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.431004	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,528,812	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,724,414	6.00
7.00	Medicaid cost (line 1 times line 6)	2,898,249	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,369,437	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)	99,494	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	717,642	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	309,307	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)	209,813	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,579,250	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	3,168,256	427,455	3,595,711	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,365,531	184,235	1,549,766	21.00
22.00	Partial payment by patients approved for charity care	5,403	1,188	6,591	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,360,128	183,047	1,543,175	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)	2,428,820	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	379,699	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,049,121	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	883,179	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,426,354	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,005,604	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		11,577	11,577	0	11,577	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL		2,819,064	2,819,064	0	2,819,064	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB		262,370	262,370	0	262,370	1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,970	1,990,401	2,010,371	-5,986	2,004,385	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	661,159	6,783,259	7,444,418	-31,131	7,413,287	5.00
7.00	00700	OPERATION OF PLANT	157,976	4,865	162,841	0	162,841	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	746,416	746,416	-3,455	742,961	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	298,135	298,135	0	298,135	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,971	64,971	0	64,971	8.00
9.00	00900	HOUSEKEEPING	264,886	82,349	347,235	-20,559	326,676	9.00
10.00	01000	DIETARY	452,039	179,394	631,433	-116,842	514,591	10.00
11.00	01100	CAFETERIA	0	0	0	114,630	114,630	11.00
13.00	01300	NURSING ADMINISTRATION	566,711	64,378	631,089	-2,241	628,848	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,295	56,072	130,367	448,448	578,815	14.00
15.00	01500	PHARMACY	343,052	1,250,755	1,593,807	-1,132,560	461,247	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,619	3,965	83,584	-150	83,434	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,095,042	371,480	1,466,522	-104,983	1,361,539	30.00
31.00	03100	INTENSIVE CARE UNIT	140,534	8,186	148,720	-7,631	141,089	31.00
43.00	04300	NURSERY	140,161	3,521	143,682	-730	142,952	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	699,748	646,241	1,345,989	-152,358	1,193,631	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	50,434	50,434	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	326,951	104,064	431,015	-3,656	427,359	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	57,963	75,185	133,148	-24,006	109,142	55.00
56.00	05600	RADIOISOTOPE	138,693	63,054	201,747	-3,599	198,148	56.00
57.00	05700	CT SCAN	145,612	199,398	345,010	-29,921	315,089	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	95,724	86,286	182,010	-5,723	176,287	58.00
60.00	06000	LABORATORY	124,473	1,132,376	1,256,849	-69,066	1,187,783	60.00
66.00	06600	PHYSICAL THERAPY	261,902	110,467	372,369	-16,683	355,686	66.00
67.00	06700	OCCUPATIONAL THERAPY	79,434	1,549	80,983	-132	80,851	67.00
68.00	06800	SPEECH PATHOLOGY	64,070	172	64,242	0	64,242	68.00
69.00	06900	ELECTROCARDIOLOGY	24,637	15,795	40,432	-4,582	35,850	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	58,249	58,249	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	1,218,271	1,218,271	73.00
73.01	03480	ONCOLOGY	153,557	34,692	188,249	-7,843	180,406	73.01
73.02	03160	CARDIOPULMONARY	357,443	45,671	403,114	-15,888	387,226	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,484	9,343	97,827	-1,925	95,902	90.00
91.00	09100	EMERGENCY	959,128	945,975	1,905,103	-124,283	1,780,820	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	134,687	2,375	137,062	-2,375	134,687	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,707,950	18,473,801	26,181,751	1,724	26,183,475	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	TLMOB	0	1,724	1,724	-1,724	0	192.01
192.02	19202	OCCUPATIONAL MEDICINE	160	0	160	0	160	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	0	0	192.03
192.04	19204	VENDING ROOM	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	7,708,110	18,475,525	26,183,635	0	26,183,635	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	160,550	172,127		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	-72,250	2,746,814		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	309,614	571,984		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-85,396	1,918,989		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,205,747	8,619,034		5.00
7.00	00700	OPERATION OF PLANT	0	162,841		7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	742,961		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	298,135		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,971		8.00
9.00	00900	HOUSEKEEPING	0	326,676		9.00
10.00	01000	DIETARY	-164,194	350,397		10.00
11.00	01100	CAFETERIA	-76,325	38,305		11.00
13.00	01300	NURSING ADMINISTRATION	-6,867	621,981		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-18,583	560,232		14.00
15.00	01500	PHARMACY	-17,239	444,008		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-341	83,093		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-200,910	1,160,629		30.00
31.00	03100	INTENSIVE CARE UNIT	0	141,089		31.00
43.00	04300	NURSERY	0	142,952		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-399,330	794,301		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	50,434		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,502	419,857		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	109,142		55.00
56.00	05600	RADIOISOTOPE	0	198,148		56.00
57.00	05700	CT SCAN	-83,076	232,013		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	176,287		58.00
60.00	06000	LABORATORY	0	1,187,783		60.00
66.00	06600	PHYSICAL THERAPY	-12,181	343,505		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	80,851		67.00
68.00	06800	SPEECH PATHOLOGY	0	64,242		68.00
69.00	06900	ELECTROCARDIOLOGY	0	35,850		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	58,249		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,218,271		73.00
73.01	03480	ONCOLOGY	-15,000	165,406		73.01
73.02	03160	CARDIOPULMONARY	-4,419	382,807		73.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	95,902		90.00
91.00	09100	EMERGENCY	0	1,780,820		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	134,687		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	512,298	26,695,773		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	TLMOB	0	0		192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	160		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19204	VENDING ROOM	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	512,298	26,695,933		200.00

RECLASSIFICATIONS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 5:51 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	AA - DIETARY/CAFETERIA				
1.00	CAFETERIA	11.00	80,527	34,648	1.00
	TOTALS		80,527	34,648	
	BB - OB/NURSERY/LDR				
1.00	NURSERY	43.00	0	7,706	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	48,651	3,961	2.00
	TOTALS		48,651	11,667	
	CC - DRUGS COSTS				
1.00	PHARMACY	15.00	0	33,342	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,218,271	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	1,251,613	
	DD - SUPPLIES COSTS				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	451,124	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	58,249	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	509,373	
	EE - OCCUPATIONAL SERVICES				
1.00	OCCUPATIONAL THERAPY	67.00	0	587	1.00
	TOTALS		0	587	
500.00	Grand Total: Increases		129,178	1,807,888	500.00

RECLASSIFICATIONS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 5:51 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	AA - DIETARY/CAFETERIA						
1.00	DIETARY	10.00	80,527	34,648	0		1.00
	TOTALS		80,527	34,648			
	BB - OB/NURSERY/LDR						
1.00	NURSERY	43.00	2,267	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	46,384	11,667	0		2.00
	TOTALS		48,651	11,667			
	CC - DRUGS COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,887	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	21,350	0		2.00
3.00	DIETARY	10.00	0	7	0		3.00
4.00	CAFETERIA	11.00	0	2	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	22	0		5.00
6.00	PHARMACY	15.00	0	1,158,311	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	4,266	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	3,001	0		8.00
9.00	NURSERY	43.00	0	561	0		9.00
10.00	OPERATING ROOM	50.00	0	3,616	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	198	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	916	0		12.00
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	22,994	0		13.00
14.00	RADIOISOTOPE	56.00	0	439	0		14.00
15.00	CT SCAN	57.00	0	4,995	0		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,266	0		16.00
17.00	LABORATORY	60.00	0	103	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	990	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	20	0		19.00
20.00	ONCOLOGY	73.01	0	1,819	0		20.00
21.00	CARDIOPULMONARY	73.02	0	19	0		21.00
22.00	CLINIC	90.00	0	55	0		22.00
23.00	EMERGENCY	91.00	0	19,671	0		23.00
24.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	105	0		24.00
	TOTALS		0	1,251,613			
	DD - SUPPLIES COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	99	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	9,781	0		2.00
3.00	OPERATION OF PLANT - HOSPITAL	7.01	0	3,455	0		3.00
4.00	HOUSEKEEPING	9.00	0	20,559	0		4.00
5.00	DIETARY	10.00	0	1,660	0		5.00
6.00	CAFETERIA	11.00	0	543	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	2,241	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,654	0		8.00
9.00	PHARMACY	15.00	0	7,591	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	150	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	42,666	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	4,630	0		12.00
13.00	NURSERY	43.00	0	5,608	0		13.00
14.00	OPERATING ROOM	50.00	0	148,742	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,980	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,740	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,012	0		17.00
18.00	RADIOISOTOPE	56.00	0	3,160	0		18.00
19.00	CT SCAN	57.00	0	24,926	0		19.00
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	3,457	0		20.00
21.00	LABORATORY	60.00	0	68,963	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	15,106	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	699	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	4,582	0		24.00
25.00	ONCOLOGY	73.01	0	6,024	0		25.00
26.00	CARDIOPULMONARY	73.02	0	15,869	0		26.00
27.00	CLINIC	90.00	0	1,870	0		27.00
28.00	EMERGENCY	91.00	0	104,612	0		28.00
29.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	2,270	0		29.00
30.00	TLMOB	192.01	0	1,724	0		30.00
	TOTALS		0	509,373			
	EE - OCCUPATIONAL SERVICES						
1.00	PHYSICAL THERAPY	66.00	0	587	0		1.00
	TOTALS		0	587			
500.00	Grand Total: Decreases		129,178	1,807,888			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2015 5:51 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	954,570	0	0	0	0	1.00
2.00	Land Improvements	1,982,123	0	0	0	0	2.00
3.00	Buildings and Fixtures	31,975,073	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	8,812,757	8,176,919	0	8,176,919	279,631	6.00
7.00	HIT designated Assets	330,139	227,286	0	227,286	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,054,662	8,404,205	0	8,404,205	279,631	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	44,054,662	8,404,205	0	8,404,205	279,631	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	954,570	0	1.00
2.00	Land Improvements	1,982,123	0	2.00
3.00	Buildings and Fixtures	31,975,073	292,545	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	16,710,045	3,531,543	6.00
7.00	HIT designated Assets	557,425	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,179,236	3,824,088	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	52,179,236	3,824,088	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2015 5:51 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	11,577	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,620,700	0	1,194,250	4,114	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	256,233	0	6,137	0	0	1.02
3.00	Total (sum of lines 1-2)	1,888,510	0	1,200,387	4,114	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	11,577	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	2,819,064	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	262,370	1.02
3.00	Total (sum of lines 1-2)	0	3,093,011	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III | Date/Time Prepared: 5/27/2015 5:51 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,982,123	0	1,982,123	0.038729	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	33,413,207	0	33,413,207	0.652874	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	15,783,328	0	15,783,328	0.308397	0	1.02
3.00	Total (sum of lines 1-2)	51,178,658	0	51,178,658	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	172,127	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	1,571,101	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	565,950	0	1.02
3.00	Total (sum of lines 1-2)	0	0	0	2,309,178	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	172,127	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1,171,599	4,114	0	0	2,746,814	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	6,034	0	0	0	571,984	1.02
3.00	Total (sum of lines 1-2)	1,177,633	4,114	0	0	3,490,925	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 5:51 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL (chapter 2)	B	-19,956	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB (chapter 2)	B	-103	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	11	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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	-665,804			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	3,680,296			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-76,325	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	B	-18,583	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00	Sale of drugs to other than patients	B	-17,239	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-341	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	160,550	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	A	-224,012	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT - TLMOB	A	309,717	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	9	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 5:51 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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	-76,207	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	32.00
33.00	PHYSICIAN RECRUITMENT	A	-10,000	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	ADVERTISING - A&G	A	-400	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MARKETING COSTS	A	-120,000	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CRNA COSTS	A	-199,459	OPERATING ROOM	50.00	0	33.03
33.04	CRNA BENEFITS COSTS	A	-52,366	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	WIC PROGRAM COSTS	A	-164,310	DIETARY	10.00	0	33.05
33.06	WIC PROGRAM BENEFITS COSTS	A	-33,030	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	2014 HAF ASSESSMENT FEES	A	-1,071,123	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	2013 HAF ASSESSMENT FEES	A	-1,012,891	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOSS ON ABANDONMENT	A	97,528	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.09
33.10	OPERATING ROOM LEASES	A	99,037	OPERATING ROOM	50.00	0	33.10
33.11	ROUTINE LEASES	A	73,668	ADULTS & PEDIATRICS	30.00	0	33.11
33.12	ROUTINE CAPITAL LEASE	A	-14,581	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.12
33.13	DIETARY CAPITAL LEASE	A	-4,634	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	9	33.13
33.14	MISCELLANEOUS REVENUE	B	-41,648	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	MISCELLANEOUS REVENUE - DIETARY	B	116	DIETARY	10.00	0	33.15
33.16	LECTURE - ROUTINE	B	-150	ADULTS & PEDIATRICS	30.00	0	33.16
33.17	LECTURE - ADMIN & GENERAL	B	-50,519	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LECTURE - NURSING ADMIN	B	-6,691	NURSING ADMINISTRATION	13.00	0	33.18
33.19	PHYSICAL THERAPY OTHER REVENUE	B	-3,454	PHYSICAL THERAPY	66.00	0	33.19
33.20	NURSING ADMIN OTHER REVENUE	B	-176	NURSING ADMINISTRATION	13.00	0	33.20
33.21	RADIOLOGY OTHER REVENUE	B	-7,502	RADIOLOGY-DIAGNOSTIC	54.00	0	33.21
33.22	CARDIOPULMONARY OTHER REVENUE	B	-4,419	CARDIOPULMONARY	73.02	0	33.22
33.23	INVESTMENT FEES	A	1,644	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	CHARGEBACK - PHYSICAL THERAPY	B	-8,727	PHYSICAL THERAPY	66.00	0	33.24
33.25	CHARGEBACK - OPERATING ROOM	B	-5,608	OPERATING ROOM	50.00	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		512,298				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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2015 5:51 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.01	CAP REL COSTS-BLDG & FIXT -	BUILDING DEPRECIATION (HO)	70,182	0	1.00
2.00	1.01	CAP REL COSTS-BLDG & FIXT -	INTEREST EXPENSE (HO)	1,156,022	1,158,717	2.00
3.00	1.01	CAP REL COSTS-BLDG & FIXT -	EQUIPMENT DEPRECIATION (HO)	69,351	0	3.00
4.00	1.01	CAP REL COSTS-BLDG & FIXT -	ARRA EQUIPMENT DEPRECIATION	32,774	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	BILLING/REVENUE CYCLE (HO)	6,623	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL POOLED ALLOCATIO	1,090,717	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	A&G SHARED SERVICES	1,434,300	1,434,300	4.03
4.04	90.00	CLINIC	SHARED SERVICES	25,483	25,483	4.04
4.05	60.00	LABORATORY	SHARED SERVICES	1,000,726	1,000,726	4.05
4.06	57.00	CT SCAN	RADIOLOGY - CT SCANS - ARNET	83,076	83,076	4.06
4.07	50.00	OPERATING ROOM	SURGERY ON-CALL - ARNETT (SL	95,000	95,000	4.07
4.08	13.00	NURSING ADMINISTRATION	RESOURCE POOL (SLA)	45,712	45,712	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	10,839	10,839	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL - ARNETT ALL	2,413,344	0	4.10
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,534,149	3,853,853	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:					
6.00	B	IU HEALTH	100.00		0.00	6.00
7.00	B	IUH ARNETT	1.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 151312	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/27/2015 5:51 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	70,182	9		1.00
2.00	-2,695	11		2.00
3.00	69,351	9		3.00
4.00	32,774	9		4.00
4.01	6,623	0		4.01
4.02	1,090,717	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	2,413,344	0		4.10
5.00	3,680,296			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2015 5:51 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	274,428	274,428	0	0	0	1.00
2.00	50.00	OPERATING ROOM	293,300	293,300	0	0	0	2.00
3.00	50.00	OPERATING ROOM	95,000	0	95,000	0	0	3.00
4.00	57.00	CT SCAN	83,076	83,076	0	0	0	4.00
5.00	60.00	LABORATORY	13,775	0	13,775	0	0	5.00
6.00	73.01	ONCOLOGY	15,000	15,000	0	0	0	6.00
7.00	91.00	EMERGENCY	772,805	0	772,805	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,547,384	665,804	881,580		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	57.00	CT SCAN	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	73.01	ONCOLOGY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	30.00	ADULTS & PEDIATRICS	0	0	0	274,428		1.00
2.00	50.00	OPERATING ROOM	0	0	0	293,300		2.00
3.00	50.00	OPERATING ROOM	0	0	0	0		3.00
4.00	57.00	CT SCAN	0	0	0	83,076		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	73.01	ONCOLOGY	0	0	0	15,000		6.00
7.00	91.00	EMERGENCY	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	665,804		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/27/2015 5:51 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					39	1.00
2.00	Line 1 multiplied by 15 hours per week					585	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					189	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)					1	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					4.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,448.26	9.50	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	64.41	48.31	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)	32.21	32.21	24.16			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)					93,282	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					459	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					93,741	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)					93,741	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)					93,741	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)					6,088	24.00
25.00	Assistants (line 4 times column 3, line 11)					24	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					6,112	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)					922	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					7,034	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)					7,034	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					922	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/27/2015 5:51 pm

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)	64.41	48.31	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)	93,741		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	7,034		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)	100,775		63.00
64.00	Total cost of outside supplier services (from your records)	87,765		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	6,112		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	922		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	7,034		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	922		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	922		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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151312	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2015 5:51 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		2	1.00
2.00	Line 1 multiplied by 15 hours per week		30	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		3	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		4.85	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	5.50	2.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	64.41	48.31	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)	32.21	32.21	24.16			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)	354	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	97	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	451	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)	451	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)	60.13	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	1,804	22.00
23.00	Total salary equivalency (see instructions)	1,804	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)	97	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)	97	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)	15	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	112	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)	112	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	15	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/27/2015 5:51 pm

		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)	64.41	48.31	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)	1,804	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	112	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)	1,916	63.00
64.00	Total cost of outside supplier services (from your records)	587	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	97	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	15	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	112	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	15	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	15	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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	1.02	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	172,127	172,127				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	2,746,814	0	2,746,814			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	571,984	0	0	571,984		1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,918,989	0	0	0	1,918,989	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,619,034	21,011	176,472	133,159	172,176	5.00
7.00	00700	OPERATION OF PLANT	162,841	0	0	0	41,139	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	742,961	8,134	134,460	25,176	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	298,135	1,521	0	14,730	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	64,971	580	14,090	0	0	8.00
9.00	00900	HOUSEKEEPING	326,676	3,436	79,352	1,643	68,980	9.00
10.00	01000	DIETARY	350,397	3,614	0	35,006	64,081	10.00
11.00	01100	CAFETERIA	38,305	3,538	0	34,273	20,970	11.00
13.00	01300	NURSING ADMINISTRATION	621,981	260	0	2,524	147,580	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	560,232	2,126	51,650	0	19,348	14.00
15.00	01500	PHARMACY	444,008	2,638	64,085	0	89,336	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,093	2,387	0	23,122	22,074	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,160,629	25,490	619,141	0	273,081	30.00
31.00	03100	INTENSIVE CARE UNIT	141,089	3,053	74,165	0	36,597	31.00
43.00	04300	NURSERY	142,952	615	14,936	0	35,910	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	794,301	16,390	398,120	0	130,436	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,434	1,169	28,400	0	12,669	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,857	9,199	223,450	0	85,143	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	109,142	750	18,210	0	15,094	55.00
56.00	05600	RADIOISOTOPE	198,148	665	16,150	0	36,118	56.00
57.00	05700	CT SCAN	232,013	616	14,973	0	37,920	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	176,287	1,508	36,641	0	24,928	58.00
60.00	06000	LABORATORY	1,187,783	4,282	104,000	0	32,415	60.00
66.00	06600	PHYSICAL THERAPY	343,505	3,449	83,766	0	68,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	80,851	315	7,652	0	20,686	67.00
68.00	06800	SPEECH PATHOLOGY	64,242	151	3,679	0	16,685	68.00
69.00	06900	ELECTROCARDIOLOGY	35,850	639	15,525	0	6,416	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,249	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	1,218,271	0	0	0	0	73.00
73.01	03480	ONCOLOGY	165,406	2,837	68,904	0	39,989	73.01
73.02	03160	CARDIOPULMONARY	382,807	2,408	58,493	0	93,084	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	95,902	0	0	0	23,043	90.00
91.00	09100	EMERGENCY	1,780,820	12,277	298,204	0	249,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	134,687	5,858	142,296	0	35,075	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,695,773	140,916	2,746,814	269,633	1,918,947	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,010	0	58,217	0	192.00
192.01	19201	TLMOB	0	22,466	0	217,637	0	192.01
192.02	19202	OCCUPATIONAL MEDICINE	160	0	0	0	42	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	2,659	0	25,763	0	192.03
192.04	19204	VENDING ROOM	0	76	0	734	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	26,695,933	172,127	2,746,814	571,984	1,918,989	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4A	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,121,852	9,121,852				5.00
7.00	00700	OPERATION OF PLANT	203,980	105,876	309,856			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	910,731	472,716	16,679	1,400,126		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	314,386	163,182	3,118	0	480,686	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	79,641	41,338	1,189	8,099	0	8.00
9.00	00900	HOUSEKEEPING	480,087	249,190	7,046	45,611	1,980	9.00
10.00	01000	DIETARY	453,098	235,181	7,410	0	42,182	10.00
11.00	01100	CAFETERIA	97,086	50,393	7,254	0	41,298	11.00
13.00	01300	NURSING ADMINISTRATION	772,345	400,886	534	0	3,041	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	633,356	328,744	4,360	29,688	0	14.00
15.00	01500	PHARMACY	600,067	311,465	5,410	36,835	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,676	67,828	4,894	0	27,862	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,078,341	1,078,765	52,265	355,880	0	30.00
31.00	03100	INTENSIVE CARE UNIT	254,904	132,308	6,261	42,629	0	31.00
43.00	04300	NURSERY	194,413	100,910	1,261	8,585	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,339,247	695,137	33,607	228,836	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	92,672	48,101	2,397	16,324	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	737,649	382,877	18,862	128,438	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	143,196	74,326	1,537	10,467	0	55.00
56.00	05600	RADIOISOTOPE	251,081	130,324	1,363	9,283	0	56.00
57.00	05700	CT SCAN	285,522	148,200	1,264	8,606	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239,364	124,242	3,093	21,061	0	58.00
60.00	06000	LABORATORY	1,328,480	689,549	8,779	59,778	0	60.00
66.00	06600	PHYSICAL THERAPY	498,923	258,966	7,071	48,148	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	109,504	56,838	646	4,398	0	67.00
68.00	06800	SPEECH PATHOLOGY	84,757	43,993	311	2,115	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58,430	30,328	1,310	8,923	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,249	30,234	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	1,218,271	632,345	0	0	0	73.00
73.01	03480	ONCOLOGY	277,136	143,848	5,816	39,605	0	73.01
73.02	03160	CARDIOPULMONARY	536,792	278,622	4,938	33,621	0	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	118,945	61,739	0	0	0	90.00
91.00	09100	EMERGENCY	2,341,072	1,215,146	25,173	171,405	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	317,916	165,015	12,012	81,791	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,362,169	8,948,612	245,860	1,400,126	116,363	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,227	33,337	12,322	0	70,149	192.00
192.01	19201	TLMOB	240,103	124,626	46,066	0	262,246	192.01
192.02	19202	OCCUPATIONAL MEDICINE	202	105	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	28,422	14,752	5,453	0	31,044	192.03
192.04	19204	VENDING ROOM	810	420	155	0	884	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	26,695,933	9,121,852	309,856	1,400,126	480,686	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	130,267					8.00
9.00	00900	HOUSEKEEPING	5,485	789,399				9.00
10.00	01000	DIETARY	1,683	23,560	763,114			10.00
11.00	01100	CAFETERIA	551	22,948	0	219,530		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	15,433	1,192,239	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,978	0	3,451	0	14.00
15.00	01500	PHARMACY	0	31,209	0	7,699	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,770	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,595	137,990	734,812	37,484	333,294	30.00
31.00	03100	INTENSIVE CARE UNIT	3,351	41,000	28,302	4,336	38,494	31.00
43.00	04300	NURSERY	5,072	3,366	0	4,920	43,814	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	90,567	0	19,203	170,843	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,790	6,119	0	1,734	15,470	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,398	31,515	0	11,822	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	383	2,754	0	1,752	0	55.00
56.00	05600	RADIOISOTOPE	1,637	1,836	0	3,363	0	56.00
57.00	05700	CT SCAN	2,708	2,142	0	3,947	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	459	5,201	0	3,150	0	58.00
60.00	06000	LABORATORY	145	48,037	0	26,017	0	60.00
66.00	06600	PHYSICAL THERAPY	2,326	29,373	0	9,628	85,659	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,754	0	1,611	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,224	0	1,239	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	973	8,724	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	2,509	0	0	5,628	50,116	73.01
73.02	03160	CARDIOPULMONARY	1,767	24,477	0	13,256	117,920	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	788	36,716	0	4,230	0	90.00
91.00	09100	EMERGENCY	51,325	85,977	0	32,105	285,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,295	39,164	0	4,779	42,418	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	130,267	671,907	763,114	219,530	1,192,239	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	41,612	0	0	0	192.00
192.01	19201	TLMOB	0	36,716	0	0	0	192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	39,164	0	0	0	192.03
192.04	19204	VENDING ROOM	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	130,267	789,399	763,114	219,530	1,192,239	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	1,003,577					14.00
15.00	01500	PHARMACY	14,293	1,006,978				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	284	0	233,314			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	73,954	0	98,063	5,019,443	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,926	0	0	559,511	0	31.00
43.00	04300	NURSERY	9,722	0	12,889	384,952	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	223,176	0	27,965	2,828,581	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,433	0	4,549	192,589	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,802	0	0	1,323,363	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,822	0	0	236,237	0	55.00
56.00	05600	RADIOISOTOPE	5,658	0	0	404,545	0	56.00
57.00	05700	CT SCAN	43,076	0	0	495,465	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,549	0	0	403,119	0	58.00
60.00	06000	LABORATORY	241,612	0	0	2,402,397	0	60.00
66.00	06600	PHYSICAL THERAPY	22,513	0	0	962,607	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,218	0	0	176,969	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	133,639	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,680	0	0	117,368	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,344	0	0	198,827	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	1,006,978	0	2,857,594	0	73.00
73.01	03480	ONCOLOGY	9,930	0	0	534,588	0	73.01
73.02	03160	CARDIOPULMONARY	28,478	0	0	1,039,871	0	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,838	0	2,765	228,021	0	90.00
91.00	09100	EMERGENCY	176,175	0	87,083	4,470,948	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,828	0	0	669,218	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,000,311	1,006,978	233,314	25,639,852	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	221,647	0	192.00
192.01	19201	TLMOB	3,266	0	0	713,023	0	192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	0	0	307	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	118,835	0	192.03
192.04	19204	VENDING ROOM	0	0	0	2,269	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,003,577	1,006,978	233,314	26,695,933	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,019,443		30.00
31.00	03100	INTENSIVE CARE UNIT	559,511		31.00
43.00	04300	NURSERY	384,952		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,828,581		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	192,589		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,323,363		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	236,237		55.00
56.00	05600	RADIOISOTOPE	404,545		56.00
57.00	05700	CT SCAN	495,465		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	403,119		58.00
60.00	06000	LABORATORY	2,402,397		60.00
66.00	06600	PHYSICAL THERAPY	962,607		66.00
67.00	06700	OCCUPATIONAL THERAPY	176,969		67.00
68.00	06800	SPEECH PATHOLOGY	133,639		68.00
69.00	06900	ELECTROCARDIOLOGY	117,368		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	198,827		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,857,594		73.00
73.01	03480	ONCOLOGY	534,588		73.01
73.02	03160	CARDIOPULMONARY	1,039,871		73.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	228,021		90.00
91.00	09100	EMERGENCY	4,470,948		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	669,218		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,639,852		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	221,647		192.00
192.01	19201	TLMOB	713,023		192.01
192.02	19202	OCCUPATIONAL MEDICINE	307		192.02
192.03	19203	ARNETT SURGERY OFFICE	118,835		192.03
192.04	19204	VENDING ROOM	2,269		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	26,695,933		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	Subtotal	
			0	1.00	1.01	1.02	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	21,011	176,472	133,159	330,642	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	8,134	134,460	25,176	167,770	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	1,521	0	14,730	16,251	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	580	14,090	0	14,670	8.00
9.00	00900	HOUSEKEEPING	0	3,436	79,352	1,643	84,431	9.00
10.00	01000	DIETARY	0	3,614	0	35,006	38,620	10.00
11.00	01100	CAFETERIA	0	3,538	0	34,273	37,811	11.00
13.00	01300	NURSING ADMINISTRATION	0	260	0	2,524	2,784	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,126	51,650	0	53,776	14.00
15.00	01500	PHARMACY	0	2,638	64,085	0	66,723	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,387	0	23,122	25,509	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	25,490	619,141	0	644,631	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,053	74,165	0	77,218	31.00
43.00	04300	NURSERY	0	615	14,936	0	15,551	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,390	398,120	0	414,510	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,169	28,400	0	29,569	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,199	223,450	0	232,649	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	750	18,210	0	18,960	55.00
56.00	05600	RADIOISOTOPE	0	665	16,150	0	16,815	56.00
57.00	05700	CT SCAN	0	616	14,973	0	15,589	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,508	36,641	0	38,149	58.00
60.00	06000	LABORATORY	0	4,282	104,000	0	108,282	60.00
66.00	06600	PHYSICAL THERAPY	0	3,449	83,766	0	87,215	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	315	7,652	0	7,967	67.00
68.00	06800	SPEECH PATHOLOGY	0	151	3,679	0	3,830	68.00
69.00	06900	ELECTROCARDIOLOGY	0	639	15,525	0	16,164	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	0	2,837	68,904	0	71,741	73.01
73.02	03160	CARDIOPULMONARY	0	2,408	58,493	0	60,901	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	12,277	298,204	0	310,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	5,858	142,296	0	148,154	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	140,916	2,746,814	269,633	3,157,363	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,010	0	58,217	64,227	192.00
192.01	19201	TLMOB	0	22,466	0	217,637	240,103	192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	2,659	0	25,763	28,422	192.03
192.04	19204	VENDING ROOM	0	76	0	734	810	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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	172,127	2,746,814	571,984	3,490,925	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
			4.00	5.00	7.00	7.01	7.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	330,642				5.00
7.00	00700	OPERATION OF PLANT	0	3,838	3,838			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	0	17,134	207	185,111		7.01
7.02	00702	OPERATION OF PLANT - TLMOB	0	5,915	39	0	22,205	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,498	15	1,071	0	8.00
9.00	00900	HOUSEKEEPING	0	9,032	87	6,030	91	9.00
10.00	01000	DIETARY	0	8,525	92	0	1,949	10.00
11.00	01100	CAFETERIA	0	1,827	90	0	1,908	11.00
13.00	01300	NURSING ADMINISTRATION	0	14,531	7	0	140	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,916	54	3,925	0	14.00
15.00	01500	PHARMACY	0	11,290	67	4,870	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,459	61	0	1,287	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	39,102	642	47,051	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,796	78	5,636	0	31.00
43.00	04300	NURSERY	0	3,658	16	1,135	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	25,197	416	30,254	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,744	30	2,158	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,878	234	16,981	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,694	19	1,384	0	55.00
56.00	05600	RADIOISOTOPE	0	4,724	17	1,227	0	56.00
57.00	05700	CT SCAN	0	5,372	16	1,138	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,503	38	2,784	0	58.00
60.00	06000	LABORATORY	0	24,994	109	7,903	0	60.00
66.00	06600	PHYSICAL THERAPY	0	9,387	88	6,366	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,060	8	581	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,595	4	280	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,099	16	1,180	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,096	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	22,921	0	0	0	73.00
73.01	03480	ONCOLOGY	0	5,214	72	5,236	0	73.01
73.02	03160	CARDIOPULMONARY	0	10,099	61	4,445	0	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,238	0	0	0	90.00
91.00	09100	EMERGENCY	0	44,046	312	22,662	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	5,981	149	10,814	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	324,363	3,044	185,111	5,375	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,208	153	0	3,241	192.00
192.01	19201	TLMOB	0	4,517	571	0	12,114	192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	4	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	535	68	0	1,434	192.03
192.04	19204	VENDING ROOM	0	15	2	0	41	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	330,642	3,838	185,111	22,205	202.00

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		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE	17,254					8.00
9.00	00900	HOUSEKEEPING	727	100,398				9.00
10.00	01000	DIETARY	223	2,996	52,405			10.00
11.00	01100	CAFETERIA	73	2,919	0	44,628		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	3,137	20,599	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	506	0	702	0	14.00
15.00	01500	PHARMACY	0	3,969	0	1,565	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	360	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,112	17,551	50,461	7,621	5,758	30.00
31.00	03100	INTENSIVE CARE UNIT	444	5,214	1,944	881	665	31.00
43.00	04300	NURSERY	672	428	0	1,000	757	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,519	0	3,904	2,952	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	237	778	0	353	267	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	980	4,008	0	2,403	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	51	350	0	356	0	55.00
56.00	05600	RADIOISOTOPE	217	233	0	684	0	56.00
57.00	05700	CT SCAN	359	272	0	802	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	61	662	0	640	0	58.00
60.00	06000	LABORATORY	19	6,109	0	5,289	0	60.00
66.00	06600	PHYSICAL THERAPY	308	3,736	0	1,957	1,480	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	350	0	327	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	156	0	252	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	198	151	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
73.01	03480	ONCOLOGY	332	0	0	1,144	866	73.01
73.02	03160	CARDIOPULMONARY	234	3,113	0	2,695	2,037	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	104	4,670	0	860	0	90.00
91.00	09100	EMERGENCY	6,797	10,935	0	6,527	4,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	304	4,981	0	971	733	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,254	85,455	52,405	44,628	20,599	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,292	0	0	0	192.00
192.01	19201	TLMOB	0	4,670	0	0	0	192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	4,981	0	0	0	192.03
192.04	19204	VENDING ROOM	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	17,254	100,398	52,405	44,628	20,599	202.00

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		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
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	70,879					14.00
15.00	01500	PHARMACY	1,009	89,493				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20	0	29,696			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,223	0	12,481	835,633	0	30.00
31.00	03100	INTENSIVE CARE UNIT	560	0	0	97,436	0	31.00
43.00	04300	NURSERY	687	0	1,641	25,545	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,762	0	3,559	508,073	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	242	0	579	35,957	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339	0	0	271,472	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	129	0	0	23,943	0	55.00
56.00	05600	RADIOISOTOPE	400	0	0	24,317	0	56.00
57.00	05700	CT SCAN	3,042	0	0	26,590	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	463	0	0	47,300	0	58.00
60.00	06000	LABORATORY	17,065	0	0	169,770	0	60.00
66.00	06600	PHYSICAL THERAPY	1,590	0	0	112,127	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	86	0	0	11,379	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	6,117	0	68.00
69.00	06900	ELECTROCARDIOLOGY	613	0	0	19,421	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,793	0	0	8,889	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	89,493	0	112,414	0	73.00
73.01	03480	ONCOLOGY	701	0	0	85,306	0	73.01
73.02	03160	CARDIOPULMONARY	2,011	0	0	85,596	0	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	200	0	352	8,424	0	90.00
91.00	09100	EMERGENCY	12,443	0	11,084	430,220	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	270	0	0	172,357	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,648	89,493	29,696	3,118,286	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	74,121	0	192.00
192.01	19201	TLMOB	231	0	0	262,206	0	192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	0	0	4	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0	0	35,440	0	192.03
192.04	19204	VENDING ROOM	0	0	0	868	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	70,879	89,493	29,696	3,490,925	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL			7.01
7.02	00702	OPERATION OF PLANT - TLMOB			7.02
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	835,633		30.00
31.00	03100	INTENSIVE CARE UNIT	97,436		31.00
43.00	04300	NURSERY	25,545		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	508,073		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,957		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	271,472		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	23,943		55.00
56.00	05600	RADIOISOTOPE	24,317		56.00
57.00	05700	CT SCAN	26,590		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	47,300		58.00
60.00	06000	LABORATORY	169,770		60.00
66.00	06600	PHYSICAL THERAPY	112,127		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,379		67.00
68.00	06800	SPEECH PATHOLOGY	6,117		68.00
69.00	06900	ELECTROCARDIOLOGY	19,421		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,889		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	112,414		73.00
73.01	03480	ONCOLOGY	85,306		73.01
73.02	03160	CARDIOPULMONARY	85,596		73.02
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	8,424		90.00
91.00	09100	EMERGENCY	430,220		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	172,357		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,118,286		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	74,121		192.00
192.01	19201	TLMOB	262,206		192.01
192.02	19202	OCCUPATIONAL MEDICINE	4		192.02
192.03	19203	ARNETT SURGERY OFFICE	35,440		192.03
192.04	19204	VENDING ROOM	868		192.04
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	3,490,925		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	1.02	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	113,652					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	74,666				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	38,986			1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	7,368,974		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,873	4,797	9,076	661,159	-9,121,852	5.00
7.00	00700	OPERATION OF PLANT	0	0	0	157,976	0	7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	5,371	3,655	1,716	0	0	7.01
7.02	00702	OPERATION OF PLANT - TLMOB	1,004	0	1,004	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	383	383	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,269	2,157	112	264,886	0	9.00
10.00	01000	DIETARY	2,386	0	2,386	246,073	0	10.00
11.00	01100	CAFETERIA	2,336	0	2,336	80,527	0	11.00
13.00	01300	NURSING ADMINISTRATION	172	0	172	566,711	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,404	1,404	0	74,295	0	14.00
15.00	01500	PHARMACY	1,742	1,742	0	343,052	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,576	0	1,576	84,763	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,830	16,830	0	1,048,658	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,016	2,016	0	140,534	0	31.00
43.00	04300	NURSERY	406	406	0	137,894	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,822	10,822	0	500,877	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	772	772	0	48,651	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,074	6,074	0	326,951	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	495	495	0	57,963	0	55.00
56.00	05600	RADIOISOTOPE	439	439	0	138,693	0	56.00
57.00	05700	CT SCAN	407	407	0	145,612	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	996	996	0	95,724	0	58.00
60.00	06000	LABORATORY	2,827	2,827	0	124,473	0	60.00
66.00	06600	PHYSICAL THERAPY	2,277	2,277	0	261,902	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	208	208	0	79,434	0	67.00
68.00	06800	SPEECH PATHOLOGY	100	100	0	64,070	0	68.00
69.00	06900	ELECTROCARDIOLOGY	422	422	0	24,637	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	1,873	1,873	0	153,557	0	73.01
73.02	03160	CARDIOPULMONARY	1,590	1,590	0	357,443	0	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	88,484	0	90.00
91.00	09100	EMERGENCY	8,106	8,106	0	959,128	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	3,868	3,868	0	134,687	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	93,044	74,666	18,378	7,368,814	-9,121,852	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,968	0	3,968	0	0	192.00
192.01	19201	TLMOB	14,834	0	14,834	0	0	192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	0	0	160	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	1,756	0	1,756	0	0	192.03
192.04	19204	VENDING ROOM	50	0	50	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	172,127	2,746,814	571,984	1,918,989		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.514509	36.788016	14.671523	0.260415		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL (SQUARE FEET)	OPERATION OF PLANT - TLMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.00	7.00	7.01	7.02	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,574,081					5.00
7.00	00700	OPERATION OF PLANT	203,980	99,779				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL	910,731	5,371	66,214			7.01
7.02	00702	OPERATION OF PLANT - TLMOB	314,386	1,004	0	27,190		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	79,641	383	383	0	17,028	8.00
9.00	00900	HOUSEKEEPING	480,087	2,269	2,157	112	717	9.00
10.00	01000	DIETARY	453,098	2,386	0	2,386	220	10.00
11.00	01100	CAFETERIA	97,086	2,336	0	2,336	72	11.00
13.00	01300	NURSING ADMINISTRATION	772,345	172	0	172	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	633,356	1,404	1,404	0	0	14.00
15.00	01500	PHARMACY	600,067	1,742	1,742	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	130,676	1,576	0	1,576	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,078,341	16,830	16,830	0	5,045	30.00
31.00	03100	INTENSIVE CARE UNIT	254,904	2,016	2,016	0	438	31.00
43.00	04300	NURSERY	194,413	406	406	0	663	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,339,247	10,822	10,822	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	92,672	772	772	0	234	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	737,649	6,074	6,074	0	967	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	143,196	495	495	0	50	55.00
56.00	05600	RADIOISOTOPE	251,081	439	439	0	214	56.00
57.00	05700	CT SCAN	285,522	407	407	0	354	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239,364	996	996	0	60	58.00
60.00	06000	LABORATORY	1,328,480	2,827	2,827	0	19	60.00
66.00	06600	PHYSICAL THERAPY	498,923	2,277	2,277	0	304	66.00
67.00	06700	OCCUPATIONAL THERAPY	109,504	208	208	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	84,757	100	100	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	58,430	422	422	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,249	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	1,218,271	0	0	0	0	73.00
73.01	03480	ONCOLOGY	277,136	1,873	1,873	0	328	73.01
73.02	03160	CARDIOPULMONARY	536,792	1,590	1,590	0	231	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	118,945	0	0	0	103	90.00
91.00	09100	EMERGENCY	2,341,072	8,106	8,106	0	6,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	317,916	3,868	3,868	0	300	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,240,317	79,171	66,214	6,582	17,028	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,227	3,968	0	3,968	0	192.00
192.01	19201	TLMOB	240,103	14,834	0	14,834	0	192.01
192.02	19202	OCCUPATIONAL MEDICINE	202	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	28,422	1,756	0	1,756	0	192.03
192.04	19204	VENDING ROOM	810	50	0	50	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	9,121,852	309,856	1,400,126	480,686	130,267	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.519051	3.105423	21.145468	17.678779	7.650164	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	330,642	3,838	185,111	22,205	17,254	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.018814	0.038465	2.795647	0.816661	1.013272	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 5:51 pm

		Cost Center Description	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702	OPERATION OF PLANT - TLMOB						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,580					9.00
10.00	01000	DIETARY	77	2,912				10.00
11.00	01100	CAFETERIA	75	0	12,404			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	872	157,988		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13	0	195	0	529,772	14.00
15.00	01500	PHARMACY	102	0	435	0	7,545	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	100	0	150	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	451	2,804	2,118	44,166	39,039	30.00
31.00	03100	INTENSIVE CARE UNIT	134	108	245	5,101	4,184	31.00
43.00	04300	NURSERY	11	0	278	5,806	5,132	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	296	0	1,085	22,639	117,811	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20	0	98	2,050	1,812	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103	0	668	0	2,535	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9	0	99	0	962	55.00
56.00	05600	RADIOISOTOPE	6	0	190	0	2,987	56.00
57.00	05700	CT SCAN	7	0	223	0	22,739	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17	0	178	0	3,457	58.00
60.00	06000	LABORATORY	157	0	1,470	0	127,543	60.00
66.00	06600	PHYSICAL THERAPY	96	0	544	11,351	11,884	66.00
67.00	06700	OCCUPATIONAL THERAPY	9	0	91	0	643	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	70	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	55	1,156	4,582	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	58,249	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
73.01	03480	ONCOLOGY	0	0	318	6,641	5,242	73.01
73.02	03160	CARDIOPULMONARY	80	0	749	15,626	15,033	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	120	0	239	0	1,498	90.00
91.00	09100	EMERGENCY	281	0	1,814	37,831	93,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	128	0	270	5,621	2,021	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,196	2,912	12,404	157,988	528,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	136	0	0	0	0	192.00
192.01	19201	TLMOB	120	0	0	0	1,724	192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	0	0	0	0	192.02
192.03	19203	ARNETT SURGERY OFFICE	128	0	0	0	0	192.03
192.04	19204	VENDING ROOM	0	0	0	0	0	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	789,399	763,114	219,530	1,192,239	1,003,577	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	305.968605	262.058379	17.698323	7.546390	1.894356	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	100,398	52,405	44,628	20,599	70,879	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	38.913953	17.996223	3.597872	0.130383	0.133792	205.00

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		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			15.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT - TLMOB				1.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT - HOSPITAL				7.01
7.02	00702	OPERATION OF PLANT - TLMOB				7.02
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	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,236		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	19,013		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	2,499		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,422		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	882		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
73.02	03160	CARDIOPULMONARY	0	0		73.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	536		90.00
91.00	09100	EMERGENCY	0	16,884		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	45,236		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	TLMOB	0	0		192.01
192.02	19202	OCCUPATIONAL MEDICINE	0	0		192.02
192.03	19203	ARNETT SURGERY OFFICE	0	0		192.03
192.04	19204	VENDING ROOM	0	0		192.04
193.00	19300	NONPAID WORKERS	0	0		193.00
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)	1,006,978	233,314		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10,069.780000	5.157706		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,493	29,696		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	894.930000	0.656468		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:51 pm

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	5,019,443		5,019,443	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	559,511		559,511	0	0	31.00
43.00	04300	NURSERY	384,952		384,952	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,828,581		2,828,581	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	192,589		192,589	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,323,363		1,323,363	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	236,237		236,237	0	0	55.00
56.00	05600	RADIOISOTOPE	404,545		404,545	0	0	56.00
57.00	05700	CT SCAN	495,465		495,465	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	403,119		403,119	0	0	58.00
60.00	06000	LABORATORY	2,402,397		2,402,397	0	0	60.00
66.00	06600	PHYSICAL THERAPY	962,607	0	962,607	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,969	0	176,969	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	133,639	0	133,639	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	117,368		117,368	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	198,827		198,827	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,857,594		2,857,594	0	0	73.00
73.01	03480	ONCOLOGY	534,588		534,588	0	0	73.01
73.02	03160	CARDIOPULMONARY	1,039,871		1,039,871	0	0	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	228,021		228,021	0	0	90.00
91.00	09100	EMERGENCY	4,470,948		4,470,948	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	669,218		669,218	0	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	25,639,852	0	25,639,852	0	0	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	25,639,852	0	25,639,852	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:51 pm

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	2,733,127		2,733,127			30.00
31.00	03100	INTENSIVE CARE UNIT	262,831		262,831			31.00
43.00	04300	NURSERY	128,001		128,001			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	798,709	6,410,064	7,208,773	0.392380	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	333,069	34,150	367,219	0.524453	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	118,838	4,574,960	4,693,798	0.281939	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	38,003	691,537	729,540	0.323816	0.000000	55.00
56.00	05600	RADIOISOTOPE	362,533	2,885,244	3,247,777	0.124561	0.000000	56.00
57.00	05700	CT SCAN	327,419	5,106,722	5,434,141	0.091176	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	128,092	1,134,929	1,263,021	0.319170	0.000000	58.00
60.00	06000	LABORATORY	1,397,321	5,816,098	7,213,419	0.333046	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	396,552	737,652	1,134,204	0.848707	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	121,200	135,573	256,773	0.689204	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,509	178,686	197,195	0.677700	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	84,822	1,979,181	2,064,003	0.056864	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	124,939	303,935	428,874	0.463602	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,390,671	6,899,844	8,290,515	0.344682	0.000000	73.00
73.01	03480	ONCOLOGY	0	516,962	516,962	1.034095	0.000000	73.01
73.02	03160	CARDIOPULMONARY	442,474	405,914	848,388	1.225702	0.000000	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,824	7,824	29.143788	0.000000	90.00
91.00	09100	EMERGENCY	137,821	12,008,694	12,146,515	0.368085	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	7,347	308,380	315,727	2.119610	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	9,352,278	50,136,349	59,488,627			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,352,278	50,136,349	59,488,627			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:51 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENTS	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
73.01	03480	ONCOLOGY	0.000000		73.01
73.02	03160	CARDIOPULMONARY	0.000000		73.02
		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
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:51 pm

Title XIX | 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	5,019,443		5,019,443	0	5,019,443	30.00
31.00	03100	INTENSIVE CARE UNIT	559,511		559,511	0	559,511	31.00
43.00	04300	NURSERY	384,952		384,952	0	384,952	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,828,581		2,828,581	0	2,828,581	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	192,589		192,589	0	192,589	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,323,363		1,323,363	0	1,323,363	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	236,237		236,237	0	236,237	55.00
56.00	05600	RADIOISOTOPE	404,545		404,545	0	404,545	56.00
57.00	05700	CT SCAN	495,465		495,465	0	495,465	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	403,119		403,119	0	403,119	58.00
60.00	06000	LABORATORY	2,402,397		2,402,397	0	2,402,397	60.00
66.00	06600	PHYSICAL THERAPY	962,607	0	962,607	0	962,607	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,969	0	176,969	0	176,969	67.00
68.00	06800	SPEECH PATHOLOGY	133,639	0	133,639	0	133,639	68.00
69.00	06900	ELECTROCARDIOLOGY	117,368		117,368	0	117,368	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	198,827		198,827	0	198,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,857,594		2,857,594	0	2,857,594	73.00
73.01	03480	ONCOLOGY	534,588		534,588	0	534,588	73.01
73.02	03160	CARDIOPULMONARY	1,039,871		1,039,871	0	1,039,871	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	228,021		228,021	0	228,021	90.00
91.00	09100	EMERGENCY	4,470,948		4,470,948	0	4,470,948	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	669,218		669,218	0	669,218	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	25,639,852	0	25,639,852	0	25,639,852	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	25,639,852	0	25,639,852	0	25,639,852	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:51 pm

Title XIX | 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	2,733,127		2,733,127			30.00
31.00	03100	INTENSIVE CARE UNIT	262,831		262,831			31.00
43.00	04300	NURSERY	128,001		128,001			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	798,709	6,410,064	7,208,773	0.392380	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	333,069	34,150	367,219	0.524453	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	118,838	4,574,960	4,693,798	0.281939	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	38,003	691,537	729,540	0.323816	0.000000	55.00
56.00	05600	RADIOISOTOPE	362,533	2,885,244	3,247,777	0.124561	0.000000	56.00
57.00	05700	CT SCAN	327,419	5,106,722	5,434,141	0.091176	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	128,092	1,134,929	1,263,021	0.319170	0.000000	58.00
60.00	06000	LABORATORY	1,397,321	5,816,098	7,213,419	0.333046	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	396,552	737,652	1,134,204	0.848707	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	121,200	135,573	256,773	0.689204	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	18,509	178,686	197,195	0.677700	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	84,822	1,979,181	2,064,003	0.056864	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	124,939	303,935	428,874	0.463602	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,390,671	6,899,844	8,290,515	0.344682	0.000000	73.00
73.01	03480	ONCOLOGY	0	516,962	516,962	1.034095	0.000000	73.01
73.02	03160	CARDIOPULMONARY	442,474	405,914	848,388	1.225702	0.000000	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,824	7,824	29.143788	0.000000	90.00
91.00	09100	EMERGENCY	137,821	12,008,694	12,146,515	0.368085	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	7,347	308,380	315,727	2.119610	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	9,352,278	50,136,349	59,488,627			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,352,278	50,136,349	59,488,627			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:51 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENTS	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
73.01	03480	ONCOLOGY	0.000000		73.01
73.02	03160	CARDIOPULMONARY	0.000000		73.02
		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
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 5:51 pm

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	508,073	7,208,773	0.070480	98,432	6,937	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,957	367,219	0.097917	6,429	630	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	271,472	4,693,798	0.057836	64,436	3,727	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	23,943	729,540	0.032819	18,605	611	55.00
56.00	05600	RADIOISOTOPE	24,317	3,247,777	0.007487	244,498	1,831	56.00
57.00	05700	CT SCAN	26,590	5,434,141	0.004893	164,219	804	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	47,300	1,263,021	0.037450	87,985	3,295	58.00
60.00	06000	LABORATORY	169,770	7,213,419	0.023535	734,753	17,292	60.00
66.00	06600	PHYSICAL THERAPY	112,127	1,134,204	0.098860	161,773	15,993	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,379	256,773	0.044315	43,268	1,917	67.00
68.00	06800	SPEECH PATHOLOGY	6,117	197,195	0.031020	7,822	243	68.00
69.00	06900	ELECTROCARDIOLOGY	19,421	2,064,003	0.009409	46,553	438	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,889	428,874	0.020726	94,097	1,950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	112,414	8,290,515	0.013559	723,065	9,804	73.00
73.01	03480	ONCOLOGY	85,306	516,962	0.165014	0	0	73.01
73.02	03160	CARDIOPULMONARY	85,596	848,388	0.100893	232,110	23,418	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,424	7,824	1.076687	0	0	90.00
91.00	09100	EMERGENCY	430,220	12,146,515	0.035419	11,646	412	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	172,357	315,727	0.545905	490	267	92.01
200.00		Total (lines 50-199)	2,159,672	56,364,668		2,740,181	89,569	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 5:51 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
73.02	03160	CARDIOPULMONARY	0	0	0	0	0	73.02
		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
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/27/2015 5:51 pm

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	7,208,773	0.000000	0.000000	98,432	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	367,219	0.000000	0.000000	6,429	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,693,798	0.000000	0.000000	64,436	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	729,540	0.000000	0.000000	18,605	55.00
56.00	05600	RADIOISOTOPE	0	3,247,777	0.000000	0.000000	244,498	56.00
57.00	05700	CT SCAN	0	5,434,141	0.000000	0.000000	164,219	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,263,021	0.000000	0.000000	87,985	58.00
60.00	06000	LABORATORY	0	7,213,419	0.000000	0.000000	734,753	60.00
66.00	06600	PHYSICAL THERAPY	0	1,134,204	0.000000	0.000000	161,773	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	256,773	0.000000	0.000000	43,268	67.00
68.00	06800	SPEECH PATHOLOGY	0	197,195	0.000000	0.000000	7,822	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,064,003	0.000000	0.000000	46,553	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	428,874	0.000000	0.000000	94,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,290,515	0.000000	0.000000	723,065	73.00
73.01	03480	ONCOLOGY	0	516,962	0.000000	0.000000	0	73.01
73.02	03160	CARDIOPULMONARY	0	848,388	0.000000	0.000000	232,110	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,824	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	12,146,515	0.000000	0.000000	11,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	315,727	0.000000	0.000000	490	92.01
200.00		Total (lines 50-199)	0	56,364,668			2,740,181	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 5:51 pm

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	03480	ONCOLOGY	0	0	0		73.01
73.02	03160	CARDIOPULMONARY	0	0	0		73.02
		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
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 5:51 pm

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	0.392380	0	2,250,573	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.524453	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281939	0	1,239,768	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.323816	0	333,600	0	0	55.00
56.00	05600	RADIOISOTOPE	0.124561	0	1,120,244	0	0	56.00
57.00	05700	CT SCAN	0.091176	0	1,929,160	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.319170	0	515,108	0	0	58.00
60.00	06000	LABORATORY	0.333046	0	1,725,006	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.848707	0	334,717	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689204	0	30,471	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.677700	0	22,925	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056864	0	824,703	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463602	0	252,556	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344682	0	3,780,603	5,169	0	73.00
73.01	03480	ONCOLOGY	1.034095	0	323,453	0	0	73.01
73.02	03160	CARDIOPULMONARY	1.225702	0	204,682	0	0	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29.143788	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.368085	0	3,273,934	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2.119610	0	230,300	0	0	92.01
200.00		Subtotal (see instructions)		0	18,391,803	5,169	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	18,391,803	5,169	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 5:51 pm

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	883,080	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	349,539	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	108,025	0		55.00
56.00	05600	RADIOISOTOPE	139,539	0		56.00
57.00	05700	CT SCAN	175,893	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	164,407	0		58.00
60.00	06000	LABORATORY	574,506	0		60.00
66.00	06600	PHYSICAL THERAPY	284,077	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	21,001	0		67.00
68.00	06800	SPEECH PATHOLOGY	15,536	0		68.00
69.00	06900	ELECTROCARDIOLOGY	46,896	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,085	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,303,106	1,782		73.00
73.01	03480	ONCOLOGY	334,481	0		73.01
73.02	03160	CARDIOPULMONARY	250,879	0		73.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,205,086	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	488,146	0		92.01
200.00		Subtotal (see instructions)	6,461,282	1,782		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,461,282	1,782		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151312 | Component CCN: 15Z312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 5:51 pm

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	0.392380	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.524453	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281939	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.323816	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.124561	0	0	0	0	56.00
57.00	05700	CT SCAN	0.091176	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.319170	0	0	0	0	58.00
60.00	06000	LABORATORY	0.333046	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.848707	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689204	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.677700	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056864	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463602	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344682	0	0	0	0	73.00
73.01	03480	ONCOLOGY	1.034095	0	0	0	0	73.01
73.02	03160	CARDIOPULMONARY	1.225702	0	0	0	0	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29.143788	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.368085	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2.119610	0	0	0	0	92.01
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: 151312 | Component CCN: 15Z312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/27/2015 5:51 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
73.02	03160	CARDIOPULMONARY	0	0		73.02
		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
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 5:51 pm

Title XIX | 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	0.392380	0	130,673	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.524453	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281939	0	138,909	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.323816	0	19,493	0	0	55.00
56.00	05600	RADIOISOTOPE	0.124561	0	121,370	0	0	56.00
57.00	05700	CT SCAN	0.091176	0	133,533	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.319170	0	35,302	0	0	58.00
60.00	06000	LABORATORY	0.333046	0	233,706	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.848707	0	11,247	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689204	0	5,311	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.677700	0	31,634	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056864	0	75,970	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463602	0	13,531	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344682	0	132,438	0	0	73.00
73.01	03480	ONCOLOGY	1.034095	0	11,073	0	0	73.01
73.02	03160	CARDIOPULMONARY	1.225702	0	12,134	0	0	73.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	29.143788	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.368085	0	708,681	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2.119610	0	15,620	0	0	92.01
200.00		Subtotal (see instructions)		0	1,830,625	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	1,830,625	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 5:51 pm

Title XIX | 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	51,273	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,164	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,312	0		55.00
56.00	05600	RADIOISOTOPE	15,118	0		56.00
57.00	05700	CT SCAN	12,175	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,267	0		58.00
60.00	06000	LABORATORY	77,835	0		60.00
66.00	06600	PHYSICAL THERAPY	9,545	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,660	0		67.00
68.00	06800	SPEECH PATHOLOGY	21,438	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,320	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,273	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,649	0		73.00
73.01	03480	ONCOLOGY	11,451	0		73.01
73.02	03160	CARDIOPULMONARY	14,873	0		73.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	260,855	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	33,108	0		92.01
200.00		Subtotal (see instructions)	624,316	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	624,316	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 5:51 pm

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)	2,804	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,111	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)	2,111	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	636	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	57	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)	1,342	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)	631	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	132.15	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)	5,019,443	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)	7,533	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)	1,167,915	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,851,528	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)	3,851,528	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)	1,824.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,448,479	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,448,479	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 5:51 pm

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	559,511	108	5,180.66	52	269,394	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)	1,142,145	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,860,018	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)	1,151,260	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)	1,151,260	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 5:51 pm

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	835,633	3,851,528	0.216961	0	0	90.00
91.00	Nursing School cost	0	3,851,528	0.000000	0	0	91.00
92.00	Allied health cost	0	3,851,528	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,851,528	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 5:51 pm

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		1,117,321		30.00
31.00	03100	INTENSIVE CARE UNIT		92,100		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.392380	98,432	38,623	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.524453	6,429	3,372	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281939	64,436	18,167	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.323816	18,605	6,025	55.00
56.00	05600	RADIOISOTOPE	0.124561	244,498	30,455	56.00
57.00	05700	CT SCAN	0.091176	164,219	14,973	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.319170	87,985	28,082	58.00
60.00	06000	LABORATORY	0.333046	734,753	244,707	60.00
66.00	06600	PHYSICAL THERAPY	0.848707	161,773	137,298	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689204	43,268	29,820	67.00
68.00	06800	SPEECH PATHOLOGY	0.677700	7,822	5,301	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056864	46,553	2,647	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463602	94,097	43,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344682	723,065	249,227	73.00
73.01	03480	ONCOLOGY	1.034095	0	0	73.01
73.02	03160	CARDIOPULMONARY	1.225702	232,110	284,498	73.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	29.143788	0	0	90.00
91.00	09100	EMERGENCY	0.368085	11,646	4,287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2.119610	490	1,039	92.01
200.00		Total (sum of lines 50-94 and 96-98)		2,740,181	1,142,145	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)		2,740,181		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 15Z312 | Date/Time Prepared: 5/27/2015 5:51 pm

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	0.392380	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.524453	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281939	8,473	2,389	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.323816	4,813	1,559	55.00
56.00	05600	RADIOISOTOPE	0.124561	7,454	928	56.00
57.00	05700	CT SCAN	0.091176	5,911	539	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.319170	3,437	1,097	58.00
60.00	06000	LABORATORY	0.333046	119,195	39,697	60.00
66.00	06600	PHYSICAL THERAPY	0.848707	193,289	164,046	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689204	63,368	43,673	67.00
68.00	06800	SPEECH PATHOLOGY	0.677700	8,472	5,741	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056864	9,493	540	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463602	28,502	13,214	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344682	198,388	68,381	73.00
73.01	03480	ONCOLOGY	1.034095	0	0	73.01
73.02	03160	CARDIOPULMONARY	1.225702	62,230	76,275	73.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	29.143788	0	0	90.00
91.00	09100	EMERGENCY	0.368085	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2.119610	0	0	92.01
200.00		Total (sum of lines 50-94 and 96-98)		713,025	418,079	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)		713,025		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 5:51 pm

Title XIX | 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		57,839		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		20,096		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.392380	113,999	44,731	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.524453	45,000	23,600	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281939	2,309	651	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.323816	0	0	55.00
56.00	05600	RADIOISOTOPE	0.124561	13,049	1,625	56.00
57.00	05700	CT SCAN	0.091176	10,879	992	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.319170	0	0	58.00
60.00	06000	LABORATORY	0.333046	64,105	21,350	60.00
66.00	06600	PHYSICAL THERAPY	0.848707	3,260	2,767	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.689204	187	129	67.00
68.00	06800	SPEECH PATHOLOGY	0.677700	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.056864	6,300	358	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.463602	2,340	1,085	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344682	40,053	13,806	73.00
73.01	03480	ONCOLOGY	1.034095	0	0	73.01
73.02	03160	CARDIOPULMONARY	1.225702	8,394	10,289	73.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	29.143788	0	0	90.00
91.00	09100	EMERGENCY	0.368085	10,589	3,898	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2.119610	3,290	6,974	92.01
200.00		Total (sum of lines 50-94 and 96-98)		323,754	132,255	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)		323,754		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151312	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 5:51 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,463,064	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)	6,463,064	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)	6,527,695	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)	41,989	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,332,361	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)	3,153,345	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)	3,153,345	30.00
31.00	Primary payer payments	3,657	31.00
32.00	Subtotal (line 30 minus line 31)	3,149,688	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)	470,860	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	357,854	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	385,524	36.00
37.00	Subtotal (see instructions)	3,507,542	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)	3,507,542	40.00
40.01	Sequestration adjustment (see instructions)	70,151	40.01
41.00	Interim payments	3,901,285	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-463,894	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	499,391	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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 5/27/2015 5:51 pm

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		2,637,192		3,901,285	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	08/19/2014	217,500		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)		217,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,854,692		3,901,285	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		618,506		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		463,894	6.02
7.00	Total Medicare program liability (see instructions)		3,473,198		3,437,391	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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 5:51 pm

Component CCN: 15Z312 | 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		1,158,203		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	08/19/2014	131,600		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)		131,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,289,803		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		252,655		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,542,458		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: 151312	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/27/2015 5:51 pm
	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	877	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,394	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	127	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,219	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	59,488,627	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,595,711	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	233,504	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	217,042	8.00
9.00	Sequestration adjustment amount (see instructions)	4,341	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	212,701	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	217,301	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)	-4,600	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151312 Component CCN: 15Z312	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/27/2015 5:51 pm
	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)	1,162,773	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)	422,260	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	631	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)	1,585,033	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,585,033	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)	1,585,033	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,096	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)	1,573,937	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,573,937	0	19.00
19.01	Sequestration adjustment (see instructions)	31,479	0	19.01
20.00	Interim payments	1,289,803	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)	252,655	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	121,399	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151312	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/27/2015 5:51 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,860,018	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)	3,860,018	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,898,618	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)	3,898,618	19.00
20.00	Deductibles (exclude professional component)	371,519	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,527,099	22.00
23.00	Coinsurance	4,864	23.00
24.00	Subtotal (line 22 minus line 23)	3,522,235	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28,743	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	21,845	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,606	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,544,080	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)	3,544,080	30.00
30.01	Sequestration adjustment (see instructions)	70,882	30.01
31.00	Interim payments	2,854,692	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)	618,506	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	298,549	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/27/2015 5:51 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	7,699,000	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,564,000	0	0	0	4.00
5.00	Other receivable	1,643,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	320,000	0	0	0	7.00
8.00	Prepaid expenses	102,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-2,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,326,000	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	973,000	0	0	0	12.00
13.00	Land improvements	149,000	0	0	0	13.00
14.00	Accumulated depreciation	-66,000	0	0	0	14.00
15.00	Buildings	30,188,000	0	0	0	15.00
16.00	Accumulated depreciation	-2,418,000	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,544,000	0	0	0	19.00
20.00	Accumulated depreciation	-565,000	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,400,969	0	0	0	23.00
24.00	Accumulated depreciation	-1,914,521	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	561,031	0	0	0	27.00
28.00	Accumulated depreciation	-107,479	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)	32,745,000	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,062,000	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	297,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,359,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,430,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,303,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,023,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	516,000	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	3,843,000	0	0	0	43.00
44.00	Other current liabilities	119,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,804,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	22,621,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	59,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	22,680,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	30,484,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,946,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	15,946,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,430,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/27/2015 5:51 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,429,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,508,000				2.00
3.00	Total (sum of line 1 and line 2)		15,937,000		0		3.00
4.00	RECONCILING ITEM	9,000		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)		9,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		15,946,000		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)		15,946,000		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	RECONCILING ITEM		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: 151312 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2015 5:51 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,025,169		2,025,169	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)	2,025,169		2,025,169	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	262,831		262,831	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)	262,831		262,831	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,288,000		2,288,000	17.00
18.00	Ancillary services	6,370,000	45,941,000	52,311,000	18.00
19.00	Outpatient services	0	5,756,000	5,756,000	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,658,000	51,697,000	60,355,000	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,183,635		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	BAD DEBT EXPENSE	2,452,000			38.00
39.00	RECONCILING DIFFERENCE	3,635			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		2,455,635		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,728,000		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151312	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/27/2015 5:51 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	60,355,000	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,258,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,097,000	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,728,000	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,369,000	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	180,000	6.00
7.00	Income from investments	17,000	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	117,000	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	66,000	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	-34,000	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.)	57,000	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	6,000	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	483,000	22.00
23.00	Governmental appropriations	234,000	23.00
24.00	MEALS ON WHEELS	13,000	24.00
25.00	Total other income (sum of lines 6-24)	1,139,000	25.00
26.00	Total (line 5 plus line 25)	4,508,000	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)	4,508,000	29.00