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

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/27/2015 3:52 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/27/2015 Time: 3:52 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 RIVERVIEW HOSPITAL (150059) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/27/2015 Time: 3:52 pm
:wa8flueIl8MFO8DAkHYKY6aEyg740
3HXbsOLPEfXOMkLUWRwX19rZnYkEop
ZQ991O1IZhOMCYRJ

PI: Date: 5/27/2015 Time: 3:52 pm
tlWCjbcmY.MNzRZcMUEOMiV1ZomKGO
J0B1a0fkJJ94CxM3sQVYdFS4XxqRCQ
43RD0ny6lg03cSYO

(Signed) Brenda Bolin
Officer or Administrator of Provider(s)

CFO
Title

5/28/15
Date

		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	155,251	113,177	141,312	-92,812	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	45,805	0		-69,477	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	201,056	113,177	141,312	-162,289	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 3:36 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 395 WESTFIELD ROAD	PO Box:			1.00
2.00	City: NOBLESVILLE	State: IN	Zip Code: 46060-	County: HAMILTON	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	RIVERVIEW HOSPITAL	150059	26900	1	07/07/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	RIVERVIEW HOSPITAL REHAB	15T059	26900	5	01/01/1994	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	RIVERVIEW HOSPITAL SNF	155669	26900		10/26/1999	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	773	370	0	0	1,054	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.	266	71	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 3:36 pm

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

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

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

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

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

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	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.	Y			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)	N		0	76.00

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	558,554	374,002	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 3:36 pm

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 3:36 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2014	12/31/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 3:36 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)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/23/2015	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.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	02/11/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 3:36 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					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.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					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.					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					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					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.					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.					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.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					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.					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.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					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.	MICHAEL	ALESSANDRINI			41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959	MALESSANDRINI@BLUEANDCO.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 3:36 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)	02/11/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2015 3:36 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	90	32,850	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		90	32,850	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		105	38,325	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	24	8,760		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	25	9,125		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		154				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: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 3:36 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)	5,221	703	12,774			1.00
2.00	HMO and other (see instructions)	1,708	1,424				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	473	71				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,221	703	12,774			7.00
8.00	INTENSIVE CARE UNIT	1,371	0	2,762			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	6,592	703	15,536	0.00	1,079.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	3,630	266	5,548	0.00	27.73	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,349	0	4,820	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	1,107.46	27.00
28.00	Observation Bed Days		92	1,825			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	70	228			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: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 3:36 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	1,557	128	3,810	1.00
2.00	HMO and other (see instructions)			382	344		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,557	128	3,810	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	301	19	455	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2015 3:36 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	64,715,554	2,733,933	67,449,487	1,901,741.00	35.47	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		23,353,739	299,019	23,652,758	519,687.00	45.51	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		184,547	0	184,547	1,321.00	139.70	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		315,277	0	315,277	1,671.00	188.68	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,439,207	0	10,439,207			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		3,629,662	0	3,629,662			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	2,018,562	-1,329,292	689,270	15,129.00	45.56	26.00
27.00	Administrative & General	5.00	7,468,772	213,488	7,682,260	260,699.00	29.47	27.00
28.00	Administrative & General under contract (see inst.)		557,336	0	557,336	4,524.00	123.20	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,478,439	42,260	1,520,699	56,815.00	26.77	30.00
31.00	Laundry & Linen Service	8.00	23,868	682	24,550	2,273.00	10.80	31.00
32.00	Housekeeping	9.00	829,027	23,697	852,724	59,267.00	14.39	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	934,933	-644,667	290,266	17,392.00	16.69	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	615,852	615,852	40,641.00	15.15	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	706,347	20,190	726,537	14,453.00	50.27	38.00
39.00	Central Services and Supply	14.00	454,778	184,379	639,157	25,117.00	25.45	39.00
40.00	Pharmacy	15.00	1,889,952	54,023	1,943,975	44,339.00	43.84	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2015 3:36 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	558,887	15,975	574,862	27,110.00	21.20	41.00
42.00	Social Service	17.00	509,232	14,556	523,788	10,121.00	51.75	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/27/2015 3:36 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		65,272,890	2,733,933	68,006,823	1,906,265.00	35.68	1.00
2.00	Excluded area salaries (see instructions)		23,353,739	299,019	23,652,758	519,687.00	45.51	2.00
3.00	Subtotal salaries (line 1 minus line 2)		41,919,151	2,434,914	44,354,065	1,386,578.00	31.99	3.00
4.00	Subtotal other wages & related costs (see inst.)		499,824	0	499,824	2,992.00	167.05	4.00
5.00	Subtotal wage-related costs (see inst.)		10,439,207	0	10,439,207	0.00	23.54	5.00
6.00	Total (sum of lines 3 thru 5)		52,858,182	2,434,914	55,293,096	1,389,570.00	39.79	6.00
7.00	Total overhead cost (see instructions)		17,430,133	-788,857	16,641,276	577,880.00	28.80	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/27/2015 3:36 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,045,154	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6,807,095	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	152,818	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	52,426	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	188,872	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	228,615	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	4,362,862	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	65,970	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	71,333	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,975,145	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V | Date/Time Prepared: 5/27/2015 3:36 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet S-7 Date/Time Prepared: 5/27/2015 3:36 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	13	0	13	3.00
4.00		RUL	74	0	74	4.00
5.00		RVX	57	0	57	5.00
6.00		RVL	66	0	66	6.00
7.00		RHX	19	0	19	7.00
8.00		RHL	15	0	15	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	554	0	554	12.00
13.00		RUB	1,105	0	1,105	13.00
14.00		RUA	413	0	413	14.00
15.00		RVC	390	0	390	15.00
16.00		RVB	355	0	355	16.00
17.00		RVA	79	0	79	17.00
18.00		RHC	62	0	62	18.00
19.00		RHB	4	0	4	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	5	0	5	21.00
22.00		RMB	6	0	6	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	3	0	3	28.00
29.00		HE2	16	0	16	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	6	0	6	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	14	0	14	36.00
37.00		LE2	7	0	7	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	6	0	6	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	5	0	5	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	4	0	4	47.00
48.00		CD1	11	0	11	48.00
49.00		CC2	5	0	5	49.00
50.00		CC1	9	0	9	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	21	0	21	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	16	0	16	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/27/2015 3:36 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	2	0	2	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	7	0	7	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,349	0	3,349	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	26900	26900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,456,021			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/27/2015 3:36 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)	0.341663	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,054,756	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	22,698,035	6.00
7.00	Medicaid cost (line 1 times line 6)	7,755,079	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)	4,700,323	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,700,323	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	3,957,481	0	3,957,481	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,352,125	0	1,352,125	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,352,125	0	1,352,125	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)	10,560,570	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	151,536	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	10,409,034	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,556,382	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,908,507	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,608,830	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		12,619,218	12,619,218	-122,293	12,496,925	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,018,562	6,359,503	8,378,065	-757,735	7,620,330	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,468,772	17,298,447	24,767,219	-666,922	24,100,297	5.00
7.00	00700	OPERATION OF PLANT	1,478,439	4,427,914	5,906,353	44,901	5,951,254	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,868	324,131	347,999	725	348,724	8.00
9.00	00900	HOUSEKEEPING	829,027	644,148	1,473,175	25,178	1,498,353	9.00
10.00	01000	DIETARY	934,933	1,563,630	2,498,563	-1,765,866	732,697	10.00
11.00	01100	CAFETERIA	0	0	0	1,645,835	1,645,835	11.00
13.00	01300	NURSING ADMINISTRATION	706,347	104,035	810,382	21,452	831,834	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	454,778	13,235,126	13,689,904	682,437	14,372,341	14.00
15.00	01500	PHARMACY	1,889,952	8,190,531	10,080,483	57,399	10,137,882	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	558,887	675,962	1,234,849	16,973	1,251,822	16.00
17.00	01700	SOCIAL SERVICE	509,232	231,257	740,489	15,466	755,955	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,057,486	733,396	6,790,882	738,343	7,529,225	30.00
31.00	03100	INTENSIVE CARE UNIT	1,781,506	196,243	1,977,749	131,469	2,109,218	31.00
41.00	04100	SUBPROVIDER - IRF	1,119,964	937,966	2,057,930	34,014	2,091,944	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,172,521	2,172,521	-37,108	2,135,413	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,530,059	6,856,480	8,386,539	-811,353	7,575,186	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,535,933	773,137	2,309,070	60,747	2,369,817	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	359,335	437,555	796,890	10,829	807,719	55.00
57.00	05700	CT SCAN	222,575	36,043	258,618	6,760	265,378	57.00
57.01	03630	ULTRA SOUND	149,506	18,290	167,796	4,540	172,336	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	158,205	29,925	188,130	4,805	192,935	58.00
59.00	05900	CARDIAC CATHETERIZATION	718,031	305,518	1,023,549	21,841	1,045,390	59.00
60.00	06000	LABORATORY	2,245,828	2,719,092	4,964,920	124,802	5,089,722	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	618,456	618,456	0	618,456	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	923,258	158,699	1,081,957	105,402	1,187,359	65.00
66.00	06600	PHYSICAL THERAPY	3,578,798	1,400,757	4,979,555	108,691	5,088,246	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	601,488	74,185	675,673	125,634	801,307	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,130,572	1,130,572	0	1,130,572	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	274,350	274,350	0	274,350	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	652,759	129,724	782,483	19,825	802,308	76.01
76.02	03070	WOMEN'S CENTER	318,933	53,970	372,903	9,686	382,589	76.02
76.03	03330	ENDOSCOPY	413,800	61,934	475,734	12,576	488,310	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,137,567	555,758	1,693,325	-14,585	1,678,740	90.00
90.01	09001	OUTPATIENT	340,093	433,710	773,803	16,329	790,132	90.01
91.00	09100	EMERGENCY	1,763,858	682,667	2,446,525	73,569	2,520,094	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	55,648	13,671	69,319	1,690	71,009	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,537,427	86,478,521	129,015,948	-53,944	128,962,004	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	91,677	157,277	248,954	2,785	251,739	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,682,100	12,917,575	33,599,675	-124,618	33,475,057	192.00
192.01	19201	FOUNDATION	158,118	11,846	169,964	4,802	174,766	192.01
192.02	19202	CLINICS	820,966	177,072	998,038	9,637	1,007,675	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	69	69	0	69	192.03
192.04	19207	WESTFIELD SCHOOLS	172,076	37,184	209,260	5,226	214,486	192.04
192.05	19203	PRACTICE MANAGEMENT	253,190	-338,984	-85,794	7,687	-78,107	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	347,489	347,489	0	347,489	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	148,958	148,958	0	148,958	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	148,425	148,425	194.01
200.00		TOTAL (SUM OF LINES 118-199)	64,715,554	99,937,007	164,652,561	0	164,652,561	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-347	12,496,578		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-34,224	7,586,106		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,177,701	15,922,596		5.00
7.00	00700	OPERATION OF PLANT	-53,498	5,897,756		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	348,724		8.00
9.00	00900	HOUSEKEEPING	0	1,498,353		9.00
10.00	01000	DIETARY	0	732,697		10.00
11.00	01100	CAFETERIA	-626,526	1,019,309		11.00
13.00	01300	NURSING ADMINISTRATION	0	831,834		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,372,341		14.00
15.00	01500	PHARMACY	-3,600	10,134,282		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,335	1,249,487		16.00
17.00	01700	SOCIAL SERVICE	0	755,955		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-554,375	6,974,850		30.00
31.00	03100	INTENSIVE CARE UNIT	-35,697	2,073,521		31.00
41.00	04100	SUBPROVIDER - IRF	0	2,091,944		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	-125,211	2,010,202		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,404,715	5,170,471		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-455	2,369,362		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	807,719		55.00
57.00	05700	CT SCAN	0	265,378		57.00
57.01	03630	ULTRA SOUND	0	172,336		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	192,935		58.00
59.00	05900	CARDIAC CATHETERIZATION	-170,833	874,557		59.00
60.00	06000	LABORATORY	-80,254	5,009,468		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	618,456		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-35,697	1,151,662		65.00
66.00	06600	PHYSICAL THERAPY	0	5,088,246		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	801,307		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,130,572		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	274,350		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	0	802,308		76.01
76.02	03070	WOMEN'S CENTER	-400	382,189		76.02
76.03	03330	ENDOSCOPY	0	488,310		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-128,382	1,550,358		90.00
90.01	09001	OUTPATIENT	0	790,132		90.01
91.00	09100	EMERGENCY	0	2,520,094		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-5,096	65,913		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,439,346	116,522,658		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	251,739		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,475,057		192.00
192.01	19201	FOUNDATION	0	174,766		192.01
192.02	19202	CLINICS	0	1,007,675		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	69		192.03
192.04	19207	WESTFIELD SCHOOLS	0	214,486		192.04
192.05	19203	PRACTICE MANAGEMENT	0	-78,107		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	347,489		192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	148,958		192.08
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	WORKMED	0	0		194.00
194.01	07951	MEALS ON WHEELS	0	148,425		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-12,439,346	152,213,215		200.00

RECLASSIFICATIONS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 3:36 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	615,852	1,029,983		1.00
	0		615,852	1,029,983		
	B - MEALS ON WHEELS					
1.00	MEALS ON WHEELS	194.01	55,539	92,886		1.00
	0		55,539	92,886		
	C - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	122,293		1.00
	0		0	122,293		
	D - MED SUPPLY RECLASS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	483,982		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	34		2.00
3.00	ENDOSCOPY	76.03	0	9		3.00
4.00	ENDOSCOPY					4.00
5.00						5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	484,025		
	E - RSMA RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	654,638		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	171,380	13,264		2.00
3.00	OPERATING ROOM	50.00	2,562,553	185,707		3.00
	0		2,733,933	853,609		
	F - PHYSICIAN PROFESSIONAL FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	554,375		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,100		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	112,500		3.00
4.00	EMERGENCY	91.00	0	20,000		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	77,363		5.00
6.00	OPERATING ROOM	50.00	0	22,750		6.00
7.00	LABORATORY	60.00	0	56,595		7.00
8.00	RESPIRATORY THERAPY	65.00	0	77,363		8.00
9.00	OUTPATIENT	90.01	0	6,000		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	75,000		10.00
	0		0	1,016,046		
	G - BONUS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	213,488	13,343		1.00
2.00	OPERATION OF PLANT	7.00	42,260	2,641		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	682	43		3.00
4.00	HOUSEKEEPING	9.00	23,697	1,481		4.00
5.00	DIETARY	10.00	26,724	1,670		5.00
6.00	NURSING ADMINISTRATION	13.00	20,190	1,262		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	12,999	812		7.00
8.00	PHARMACY	15.00	54,023	3,376		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	15,975	998		9.00
10.00	SOCIAL SERVICE	17.00	14,556	910		10.00
11.00	ADULTS & PEDIATRICS	30.00	173,148	10,822		11.00
12.00	INTENSIVE CARE UNIT	31.00	50,923	3,183		12.00
13.00	SUBPROVIDER - IRF	41.00	32,013	2,001		13.00
14.00	OPERATING ROOM	50.00	4,968	311		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	43,903	2,744		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	10,271	642		16.00
17.00	CT SCAN	57.00	6,362	398		17.00
18.00	ULTRA SOUND	57.01	4,273	267		18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	4,522	283		19.00
20.00	CARDIAC CATHETERIZATION	59.00	20,524	1,283		20.00
21.00	LABORATORY	60.00	64,195	4,012		21.00
22.00	RESPIRATORY THERAPY	65.00	26,390	1,649		22.00
23.00	PHYSICAL THERAPY	66.00	102,297	6,394		23.00
24.00	ELECTROCARDIOLOGY	69.00	17,193	1,075		24.00
25.00	CARDIAC REHAB	76.01	18,659	1,166		25.00
26.00	WOMEN'S CENTER	76.02	9,116	570		26.00
27.00	ENDOSCOPY	76.03	11,828	739		27.00
28.00	CLINIC	90.00	32,507	2,032		28.00
29.00	OUTPATIENT	90.01	9,721	608		29.00
30.00	EMERGENCY	91.00	50,418	3,151		30.00
31.00	AMBULANCE SERVICES	95.00	1,591	99		31.00
32.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	2,621	164		32.00
33.00	PHYSICIANS' PRIVATE OFFICES	192.00	181,511	11,344		33.00
34.00	FOUNDATION	192.01	4,520	282		34.00
35.00	CLINICS	192.02	9,070	567		35.00
36.00	WESTFIELD SCHOOLS	192.04	4,919	307		36.00

RECLASSIFICATIONS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 3:36 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
37.00	PRACTICE MANAGEMENT	192.05	7,235	452	37.00
	TOTALS		1,329,292	83,081	
500.00	Grand Total: Increases		4,734,616	3,681,923	500.00

RECLASSIFICATIONS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 3:36 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	615,852	1,029,983	0		1.00
	0		615,852	1,029,983			
	B - MEALS ON WHEELS						
1.00	DIETARY	10.00	55,539	92,886	0		1.00
	0		55,539	92,886			
	C - INSURANCE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	122,293	12		1.00
	0		0	122,293			
	D - MED SUPPLY RECLASS						
1.00	SKILLED NURSING FACILITY	44.00	0	37,108	0		1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	0	84	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	5,134	0		3.00
4.00	CLINIC	90.00	0	49,124	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	392,473	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	2	0		6.00
7.00	OPERATING ROOM	50.00	0	100	0		7.00
	0		0	484,025			
	E - RSMA RECLASS						
1.00	OPERATING ROOM	50.00	0	3,587,542	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	3,587,542			
	F - PHYSICIAN PROFESSIONAL FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,016,046	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	0		0	1,016,046			
	G - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,329,292	83,081	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
36.00		0.00	0	0	0		36.00
37.00		0.00	0	0	0		37.00

RECLASSIFICATIONS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 3:36 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	TOTALS		1,329,292	83,081			
500.00	Grand Total: Decreases		2,000,683	6,415,856			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2015 3:36 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	9,814,610	6,102,774	0	6,102,774	0	1.00
2.00	Land Improvements	2,491,524	133,875	0	133,875	0	2.00
3.00	Buildings and Fixtures	101,789,134	11,425,517	0	11,425,517	9,032,886	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	34,518,797	2,470,535	0	2,470,535	35,775	5.00
6.00	Movable Equipment	72,517,731	8,068,751	0	8,068,751	18,218,382	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	221,131,796	28,201,452	0	28,201,452	27,287,043	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	221,131,796	28,201,452	0	28,201,452	27,287,043	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	15,917,384	0	1.00
2.00	Land Improvements	2,625,399	0	2.00
3.00	Buildings and Fixtures	104,181,765	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	36,953,557	0	5.00
6.00	Movable Equipment	62,368,100	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	222,046,205	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	222,046,205	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2015 3:36 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	10,462,802	0	1,882,420	273,996	0	1.00
3.00	Total (sum of lines 1-2)	10,462,802	0	1,882,420	273,996	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12,619,218		1.00
3.00	Total (sum of lines 1-2)	0	12,619,218		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2015 3:36 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	10,462,802	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	10,462,802	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,882,073	151,703	0	0	12,496,578	1.00
3.00	Total (sum of lines 1-2)	1,882,073	151,703	0	0	12,496,578	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 3:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - 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	-2,151,264			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	-376,080			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-626,526	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - 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
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		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 3:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER REVENUES ->HOSPITAL OUTPATIENT	B	-2,810	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER REV MEDICAL REPORT	B	-2,335	MEDICAL RECORDS & LIBRARY	16.00	0	33.01
33.02	OTHER REV RADIOLOGY FILM	B	-35	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03	OTHER REVENUES-OTHER REV-FITNESS	B	-4,408	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER REVENUES ->PURCHASE DISCOUNTS	B	-17,686	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	OTHER REV ->VHA DIVIDENDS: OTHER	B	-55,850	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	EDUCATION OTHER REVENUE	B	-550	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	NON-OP EXPENSE INVESTMENT FEES	B	268,627	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	EMPLOYEE HEALTH/INF CONT - OTHER REV	B	-2,358	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	PHARMACY -> OTHER REVENUE	B	-3,600	PHARMACY	15.00	0	33.09
34.00	RADIOLOGY-OTHER REVENUE-CDS FOR LEGA	B	-420	RADIOLOGY-DIAGNOSTIC	54.00	0	34.00
36.00	AMBULANCE ->OTHER REVENUE	B	-5,096	AMBULANCE SERVICES	95.00	0	36.00
38.00	LABORATORY -> OTHER REVENUE	B	-80,254	LABORATORY	60.00	0	38.00
39.00	EMPLOYEE WELLNESS- OTHER REVENUE	B	-17,446	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	PR/MARKETING- OTHER REVENUE	B	-1,735	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN BILLING -> OTHER REVENUE	B	-300	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	205 CONNER STREET- > RENTAL INCOME	B	-21,072	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	MISCELLANEOUS INTEREST INCOME	B	-39,887	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.01	INTEREST INCOME - BOND FUNDS	B	-347	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.01
45.03	RENTAL INCOME - TCU	B	-125,211	SKILLED NURSING FACILITY	44.00	0	45.03
45.06	COMMUNITY RELATIONS	A	-1,647,674	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	COMMUNITY RELATIONS BENEFITS	A	-13,745	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.07
45.08	CRNA	A	-675,000	OPERATING ROOM	50.00	0	45.08
45.10	PHYSICIAN RECRUITMENT	A	-36,066	ADMINISTRATIVE & GENERAL	5.00	0	45.10
45.11	IHA LOBBYING EXPENSE	A	-2,464	ADMINISTRATIVE & GENERAL	5.00	0	45.11
45.12	HAF EXPENSE	A	-6,396,508	ADMINISTRATIVE & GENERAL	5.00	0	45.12
45.13	ENGINEERING - ENERGY REBATES	B	-34,920	OPERATION OF PLANT	7.00	0	45.13
45.14	SCHOOL FITNESS CONTRACT - OTHER REV	B	-126,299	CLINIC	90.00	0	45.14
45.15	COMM HEALTH CLINIC - OTHER GRANT REV	B	-2,083	CLINIC	90.00	0	45.15
45.16	HUMAN RESOURCES-OTHER REVENUE	B	-125	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.16
45.18	OTHER REVENUES-DONATED EQUIPMENT	A	-218,841	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19	ENGINEERING - OTHER REVENUE	B	-18,578	OPERATION OF PLANT	7.00	0	45.19
45.20	WOMEN'S CTR> -OTHER REVENUE-SILVER R	B	-400	WOMEN'S CENTER	76.02	0	45.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,439,346				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: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/27/2015 3:36 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	50.00	OPERATING ROOM	OPERATING ROOM	3,605,897	3,981,977	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	3,605,897	3,981,977	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/27/2015 3:36 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	-376,080	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-376,080			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: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2015 3:36 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,027	1,027	0	177,200	0	1.00
2.00	50.00	OPERATING ROOM	1,353,635	1,353,635	0	208,000	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	170,833	170,833	0	225,300	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	554,375	554,375	0	208,000	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	35,697	35,697	0	177,200	0	5.00
6.00	65.00	RESPIRATORY THERAPY	35,697	35,697	0	177,200	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,151,264	2,151,264	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,027		1.00
2.00	50.00	OPERATING ROOM	0	0	0	1,353,635		2.00
3.00	59.00	CARDIAC CATHETERIZATION	0	0	0	170,833		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	554,375		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	35,697		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	35,697		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,151,264		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	12,496,578	12,496,578				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,586,106	62,261	7,648,367			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,922,596	1,035,234	880,118	17,837,948	17,837,948	5.00
7.00	00700	OPERATION OF PLANT	5,897,756	4,578,368	174,219	10,650,343	1,413,301	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	348,724	50,251	2,813	401,788	53,317	8.00
9.00	00900	HOUSEKEEPING	1,498,353	31,689	97,692	1,627,734	216,000	9.00
10.00	01000	DIETARY	732,697	76,862	33,254	842,813	111,841	10.00
11.00	01100	CAFETERIA	1,019,309	156,085	70,555	1,245,949	165,337	11.00
13.00	01300	NURSING ADMINISTRATION	831,834	0	83,236	915,070	121,430	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,372,341	94,585	73,225	14,540,151	1,929,478	14.00
15.00	01500	PHARMACY	10,134,282	150,575	222,711	10,507,568	1,394,354	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,249,487	78,385	65,859	1,393,731	184,948	16.00
17.00	01700	SOCIAL SERVICE	755,955	41,719	60,008	857,682	113,814	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,974,850	1,942,239	713,813	9,630,902	1,278,021	30.00
31.00	03100	INTENSIVE CARE UNIT	2,073,521	366,154	209,932	2,649,607	351,603	31.00
41.00	04100	SUBPROVIDER - IRF	2,091,944	340,584	131,976	2,564,504	340,310	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,010,202	235,004	0	2,245,206	297,939	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,170,471	720,170	469,439	6,360,080	843,983	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,369,362	317,782	180,994	2,868,138	380,602	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	807,719	180,309	42,344	1,030,372	136,730	55.00
57.00	05700	CT SCAN	265,378	0	26,228	291,606	38,696	57.00
57.01	03630	ULTRA SOUND	172,336	0	17,618	189,954	25,207	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	192,935	0	18,643	211,578	28,076	58.00
59.00	05900	CARDIAC CATHETERIZATION	874,557	73,104	84,613	1,032,274	136,983	59.00
60.00	06000	LABORATORY	5,009,468	312,119	264,648	5,586,235	741,293	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	618,456	95,779	0	714,235	94,779	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,151,662	46,823	108,796	1,307,281	173,476	65.00
66.00	06600	PHYSICAL THERAPY	5,088,246	0	421,725	5,509,971	731,173	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	801,307	271,974	70,879	1,144,160	151,830	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,130,572	0	0	1,130,572	150,027	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	274,350	13,483	0	287,833	38,195	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	802,308	0	76,921	879,229	116,674	76.01
76.02	03070	WOMEN'S CENTER	382,189	206,615	37,583	626,387	83,122	76.02
76.03	03330	ENDOSCOPY	488,310	64,242	48,762	601,314	79,794	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,550,358	0	134,050	1,684,408	223,521	90.00
90.01	09001	OUTPATIENT	790,132	87,501	40,076	917,709	121,780	90.01
91.00	09100	EMERGENCY	2,520,094	406,832	207,853	3,134,779	415,985	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	65,913	0	6,558	72,471	9,617	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,522,658	12,036,728	5,077,141	113,491,582	12,693,236	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	251,739	120,257	10,803	382,799	50,797	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,475,057	257,856	2,390,221	36,123,134	4,793,486	192.00
192.01	19201	FOUNDATION	174,766	81,737	18,633	275,136	36,511	192.01
192.02	19202	CLINICS	1,007,675	0	95,093	1,102,768	146,337	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	69	0	0	69	9	192.03
192.04	19207	WESTFIELD SCHOOLS	214,486	0	20,277	234,763	31,153	192.04
192.05	19203	PRACTICE MANAGEMENT	-78,107	0	29,836	-48,271	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	347,489	0	0	347,489	46,112	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	148,958	0	0	148,958	19,767	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	148,425	0	6,363	154,788	20,540	194.01

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 3:36 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	4.00	4A	5.00	
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)	152,213,215	12,496,578	7,648,367	152,213,215	17,837,948	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	12,063,644					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	88,878	543,983				8.00
9.00	00900	HOUSEKEEPING	56,048	0	1,899,782			9.00
10.00	01000	DIETARY	135,944	0	3,885	1,094,483		10.00
11.00	01100	CAFETERIA	276,064	0	54,390	0	1,741,740	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,943	0	27,739	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	167,291	4,089	0	0	48,206	14.00
15.00	01500	PHARMACY	266,318	0	48,563	0	85,098	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138,638	0	9,713	0	52,031	16.00
17.00	01700	SOCIAL SERVICE	73,788	0	0	0	19,425	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,435,194	170,508	608,008	535,631	382,753	30.00
31.00	03100	INTENSIVE CARE UNIT	647,608	39,750	95,183	77,323	98,464	31.00
41.00	04100	SUBPROVIDER - IRF	602,383	42,501	122,379	258,734	73,512	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	415,645	39,453	108,781	222,795	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,273,748	28,532	236,987	0	155,219	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	562,053	31,855	31,080	0	80,536	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	318,909	4,401	9,713	0	21,273	55.00
57.00	05700	CT SCAN	0	0	0	0	12,013	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	4,537	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,943	0	9,166	58.00
59.00	05900	CARDIAC CATHETERIZATION	129,297	14,036	0	0	36,708	59.00
60.00	06000	LABORATORY	552,038	0	67,988	0	151,829	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	169,402	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	82,815	0	5,828	0	52,223	65.00
66.00	06600	PHYSICAL THERAPY	0	4,587	7,770	0	132,022	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	481,035	4,669	67,988	0	34,810	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	23,847	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	401	38,850	0	34,529	76.01
76.02	03070	WOMEN'S CENTER	365,436	2,713	42,735	0	25,275	76.02
76.03	03330	ENDOSCOPY	113,623	24,265	0	0	23,897	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	736	0	0	34,453	90.00
90.01	09001	OUTPATIENT	154,761	14,779	23,310	0	21,928	90.01
91.00	09100	EMERGENCY	719,554	73,427	165,114	0	92,735	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	4,673	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,250,317	500,702	1,752,151	1,094,483	1,715,054	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212,696	0	5,828	0	8,447	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	456,065	42,910	102,953	0	0	192.00
192.01	19201	FOUNDATION	144,566	0	0	0	11,205	192.01
192.02	19202	CLINICS	0	193	38,850	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	178	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	7,034	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,063,644	543,983	1,899,782	1,094,483	1,741,740	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,066,182					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,689,215				14.00
15.00	01500	PHARMACY	0	0	12,301,901			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,779,061		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	1,064,709	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	630,282	0	0	593,020	831,354	30.00
31.00	03100	INTENSIVE CARE UNIT	162,141	0	0	104,140	65,043	31.00
41.00	04100	SUBPROVIDER - IRF	121,052	0	0	0	91,061	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	2,893	77,251	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	613,271	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	11,571	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	23,142	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	31,821	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	170,674	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	63,641	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,689,215	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	12,301,901	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	152,707	0	0	153,317	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,066,182	16,689,215	12,301,901	1,767,490	1,064,709	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	11,571	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,066,182	16,689,215	12,301,901	1,779,061	1,064,709	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	18,095,673	0	18,095,673		30.00
31.00	03100	INTENSIVE CARE UNIT	4,290,862	0	4,290,862		31.00
41.00	04100	SUBPROVIDER - IRF	4,216,436	0	4,216,436		41.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	3,409,963	0	3,409,963		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,511,820	0	9,511,820		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,965,835	0	3,965,835		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,544,540	0	1,544,540		55.00
57.00	05700	CT SCAN	342,315	0	342,315		57.00
57.01	03630	ULTRA SOUND	219,698	0	219,698		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	250,763	0	250,763		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,349,298	0	1,349,298		59.00
60.00	06000	LABORATORY	7,131,204	0	7,131,204		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	978,416	0	978,416		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,621,623	0	1,621,623		65.00
66.00	06600	PHYSICAL THERAPY	6,556,197	0	6,556,197		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	1,948,133	0	1,948,133		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,689,215	0	16,689,215		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,280,599	0	1,280,599		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,301,901	0	12,301,901		73.00
74.00	07400	RENAL DIALYSIS	349,875	0	349,875		74.00
76.00	03020	OTHER ANCILLARY	0	0	0		76.00
76.01	03140	CARDIAC REHAB	1,069,683	0	1,069,683		76.01
76.02	03070	WOMEN'S CENTER	1,145,668	0	1,145,668		76.02
76.03	03330	ENDOSCOPY	842,893	0	842,893		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,943,118	0	1,943,118		90.00
90.01	09001	OUTPATIENT	1,254,267	0	1,254,267		90.01
91.00	09100	EMERGENCY	4,907,618	0	4,907,618		91.00
91.01	09101	SHORT STAY	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	86,761	0	86,761		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	107,304,374	0	107,304,374		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	660,567	0	660,567		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41,518,548	0	41,518,548		192.00
192.01	19201	FOUNDATION	467,418	0	467,418		192.01
192.02	19202	CLINICS	1,299,719	0	1,299,719		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	78	0	78		192.03
192.04	19207	WESTFIELD SCHOOLS	265,916	0	265,916		192.04
192.05	19203	PRACTICE MANAGEMENT	-48,093	0	-48,093		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	393,601	0	393,601		192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	168,725	0	168,725		192.08
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	WORKMED	0	0	0		194.00
194.01	07951	MEALS ON WHEELS	182,362	0	182,362		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 3:36 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118-201)	152,213,215	0	152,213,215		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	62,261	62,261	62,261		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,035,234	1,035,234	7,168	1,042,402	5.00
7.00	00700	OPERATION OF PLANT	0	4,578,368	4,578,368	1,419	82,593	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,251	50,251	23	3,116	8.00
9.00	00900	HOUSEKEEPING	0	31,689	31,689	796	12,623	9.00
10.00	01000	DIETARY	0	76,862	76,862	271	6,536	10.00
11.00	01100	CAFETERIA	0	156,085	156,085	575	9,662	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	678	7,096	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	94,585	94,585	596	112,759	14.00
15.00	01500	PHARMACY	0	150,575	150,575	1,814	81,486	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,385	78,385	536	10,808	16.00
17.00	01700	SOCIAL SERVICE	0	41,719	41,719	489	6,651	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,942,239	1,942,239	5,813	74,688	30.00
31.00	03100	INTENSIVE CARE UNIT	0	366,154	366,154	1,710	20,548	31.00
41.00	04100	SUBPROVIDER - IRF	0	340,584	340,584	1,075	19,888	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	235,004	235,004	0	17,412	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	720,170	720,170	3,823	49,322	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	317,782	317,782	1,474	22,242	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	180,309	180,309	345	7,991	55.00
57.00	05700	CT SCAN	0	0	0	214	2,261	57.00
57.01	03630	ULTRA SOUND	0	0	0	143	1,473	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	152	1,641	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	73,104	73,104	689	8,005	59.00
60.00	06000	LABORATORY	0	312,119	312,119	2,155	43,321	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	95,779	95,779	0	5,539	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	46,823	46,823	886	10,138	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,434	42,730	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	271,974	271,974	577	8,873	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	13,483	13,483	0	2,232	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	626	6,818	76.01
76.02	03070	WOMEN'S CENTER	0	206,615	206,615	306	4,858	76.02
76.03	03330	ENDOSCOPY	0	64,242	64,242	397	4,663	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,092	13,063	90.00
90.01	09001	OUTPATIENT	0	87,501	87,501	326	7,117	90.01
91.00	09100	EMERGENCY	0	406,832	406,832	1,693	24,310	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	53	562	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	12,036,728	12,036,728	41,348	741,793	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	120,257	120,257	88	2,969	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	257,856	257,856	19,439	280,082	192.00
192.01	19201	FOUNDATION	0	81,737	81,737	152	2,134	192.01
192.02	19202	CLINICS	0	0	0	774	8,552	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	1	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	165	1,821	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	243	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	2,695	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	1,155	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	52	1,200	194.01
200.00		Cross Foot Adjustments			0			200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	12,496,578	12,496,578	62,261	1,042,402	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	4,662,380					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,350	87,740				8.00
9.00	00900	HOUSEKEEPING	21,662	0	66,770			9.00
10.00	01000	DIETARY	52,540	0	137	136,346		10.00
11.00	01100	CAFETERIA	106,694	0	1,912	0	274,928	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	68	0	4,379	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	64,655	659	0	0	7,609	14.00
15.00	01500	PHARMACY	102,927	0	1,707	0	13,433	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	53,581	0	341	0	8,213	16.00
17.00	01700	SOCIAL SERVICE	28,518	0	0	0	3,066	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,327,640	27,501	21,371	66,726	60,416	30.00
31.00	03100	INTENSIVE CARE UNIT	250,289	6,411	3,345	9,633	15,542	31.00
41.00	04100	SUBPROVIDER - IRF	232,810	6,855	4,301	32,232	11,604	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	160,639	6,363	3,823	27,755	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	492,281	4,602	8,329	0	24,501	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,223	5,138	1,092	0	12,712	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	123,252	710	341	0	3,358	55.00
57.00	05700	CT SCAN	0	0	0	0	1,896	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	716	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	68	0	1,447	58.00
59.00	05900	CARDIAC CATHETERIZATION	49,971	2,264	0	0	5,794	59.00
60.00	06000	LABORATORY	213,353	0	2,390	0	23,966	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	65,471	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	32,006	0	205	0	8,243	65.00
66.00	06600	PHYSICAL THERAPY	0	740	273	0	20,839	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	185,911	753	2,390	0	5,495	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,217	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	65	1,365	0	5,450	76.01
76.02	03070	WOMEN'S CENTER	141,234	438	1,502	0	3,990	76.02
76.03	03330	ENDOSCOPY	43,913	3,914	0	0	3,772	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	119	0	0	5,438	90.00
90.01	09001	OUTPATIENT	59,812	2,384	819	0	3,461	90.01
91.00	09100	EMERGENCY	278,095	11,843	5,803	0	14,638	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	738	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,348,044	80,759	61,582	136,346	270,716	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	82,203	0	205	0	1,333	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	176,261	6,921	3,618	0	0	192.00
192.01	19201	FOUNDATION	55,872	0	0	0	1,769	192.01
192.02	19202	CLINICS	0	31	1,365	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	29	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	1,110	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,662,380	87,740	66,770	136,346	274,928	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	12,221					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	280,863				14.00
15.00	01500	PHARMACY	0	0	351,942			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	151,864		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	80,443	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,224	0	0	50,621	62,812	30.00
31.00	03100	INTENSIVE CARE UNIT	1,859	0	0	8,890	4,914	31.00
41.00	04100	SUBPROVIDER - IRF	1,388	0	0	0	6,880	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	247	5,837	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	52,350	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	988	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,975	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	2,716	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,569	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	5,433	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	280,863	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	351,942	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,750	0	0	13,087	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,221	280,863	351,942	150,876	80,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	988	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,221	280,863	351,942	151,864	80,443	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,647,051	0	3,647,051		30.00
31.00	03100	INTENSIVE CARE UNIT	689,295	0	689,295		31.00
41.00	04100	SUBPROVIDER - IRF	657,617	0	657,617		41.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	457,080	0	457,080		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,355,378	0	1,355,378		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	578,651	0	578,651		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	318,281	0	318,281		55.00
57.00	05700	CT SCAN	4,371	0	4,371		57.00
57.01	03630	ULTRA SOUND	2,332	0	2,332		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,308	0	3,308		58.00
59.00	05900	CARDIAC CATHETERIZATION	139,827	0	139,827		59.00
60.00	06000	LABORATORY	600,020	0	600,020		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	166,789	0	166,789		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	98,301	0	98,301		65.00
66.00	06600	PHYSICAL THERAPY	82,585	0	82,585		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	481,406	0	481,406		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	280,863	0	280,863		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,768	0	8,768		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	351,942	0	351,942		73.00
74.00	07400	RENAL DIALYSIS	24,932	0	24,932		74.00
76.00	03020	OTHER ANCILLARY	0	0	0		76.00
76.01	03140	CARDIAC REHAB	14,324	0	14,324		76.01
76.02	03070	WOMEN'S CENTER	358,943	0	358,943		76.02
76.03	03330	ENDOSCOPY	120,901	0	120,901		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	19,712	0	19,712		90.00
90.01	09001	OUTPATIENT	161,420	0	161,420		90.01
91.00	09100	EMERGENCY	758,051	0	758,051		91.00
91.01	09101	SHORT STAY	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,353	0	1,353		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,383,501	0	11,383,501		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	207,055	0	207,055		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	744,177	0	744,177		192.00
192.01	19201	FOUNDATION	141,664	0	141,664		192.01
192.02	19202	CLINICS	11,710	0	11,710		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	1	0	1		192.03
192.04	19207	WESTFIELD SCHOOLS	1,986	0	1,986		192.04
192.05	19203	PRACTICE MANAGEMENT	272	0	272		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	2,695	0	2,695		192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	1,155	0	1,155		192.08
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	WORKMED	0	0	0		194.00
194.01	07951	MEALS ON WHEELS	2,362	0	2,362		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 3:36 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
202.00	TOTAL (sum lines 118-201)	12,496,578	0	12,496,578		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	492,145					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,452	66,760,217				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,770	7,682,260	-17,837,948	134,423,538		5.00
7.00	00700	OPERATION OF PLANT	180,307	1,520,699	0	10,650,343	268,616	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,979	24,550	0	401,788	1,979	8.00
9.00	00900	HOUSEKEEPING	1,248	852,724	0	1,627,734	1,248	9.00
10.00	01000	DIETARY	3,027	290,266	0	842,813	3,027	10.00
11.00	01100	CAFETERIA	6,147	615,852	0	1,245,949	6,147	11.00
13.00	01300	NURSING ADMINISTRATION	0	726,537	0	915,070	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,725	639,157	0	14,540,151	3,725	14.00
15.00	01500	PHARMACY	5,930	1,943,975	0	10,507,568	5,930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,087	574,862	0	1,393,731	3,087	16.00
17.00	01700	SOCIAL SERVICE	1,643	523,788	0	857,682	1,643	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	76,490	6,230,634	0	9,630,902	76,490	30.00
31.00	03100	INTENSIVE CARE UNIT	14,420	1,832,429	0	2,649,607	14,420	31.00
41.00	04100	SUBPROVIDER - IRF	13,413	1,151,977	0	2,564,504	13,413	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,255	0	0	2,245,206	9,255	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,362	4,097,580	0	6,360,080	28,362	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,515	1,579,836	0	2,868,138	12,515	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,101	369,606	0	1,030,372	7,101	55.00
57.00	05700	CT SCAN	0	228,937	0	291,606	0	57.00
57.01	03630	ULTRA SOUND	0	153,779	0	189,954	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	162,727	0	211,578	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,879	738,555	0	1,032,274	2,879	59.00
60.00	06000	LABORATORY	12,292	2,310,023	0	5,586,235	12,292	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,772	0	0	714,235	3,772	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,844	949,648	0	1,307,281	1,844	65.00
66.00	06600	PHYSICAL THERAPY	0	3,681,095	0	5,509,971	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	10,711	618,681	0	1,144,160	10,711	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,130,572	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	531	0	0	287,833	531	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	671,418	0	879,229	0	76.01
76.02	03070	WOMEN'S CENTER	8,137	328,049	0	626,387	8,137	76.02
76.03	03330	ENDOSCOPY	2,530	425,628	0	601,314	2,530	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,170,074	0	1,684,408	0	90.00
90.01	09001	OUTPATIENT	3,446	349,814	0	917,709	3,446	90.01
91.00	09100	EMERGENCY	16,022	1,814,276	0	3,134,779	16,022	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	57,239	0	72,471	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	474,035	44,316,675	-17,837,948	95,653,634	250,506	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,736	94,298	0	382,799	4,736	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,155	20,863,611	0	36,123,134	10,155	192.00
192.01	19201	FOUNDATION	3,219	162,638	0	275,136	3,219	192.01
192.02	19202	CLINICS	0	830,036	0	1,102,768	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	69	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	176,995	0	234,763	0	192.04
192.05	19203	PRACTICE MANAGEMENT	0	260,425	48,271	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	347,489	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	148,958	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	55,539	0	154,788	0	194.01

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
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)	12,496,578	7,648,367		17,837,948	12,063,644	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.392065	0.114565		0.132700	44.910370	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		62,261		1,042,402	4,662,380	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000933		0.007755	17.357045	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,174					8.00
9.00	00900	HOUSEKEEPING	0	978				9.00
10.00	01000	DIETARY	0	2	82,196			10.00
11.00	01100	CAFETERIA	0	28	0	907,504		11.00
13.00	01300	NURSING ADMINISTRATION	0	1	0	14,453	337,350	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	550	0	0	25,117	0	14.00
15.00	01500	PHARMACY	0	25	0	44,339	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5	0	27,110	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	10,121	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,936	313	40,226	199,427	199,427	30.00
31.00	03100	INTENSIVE CARE UNIT	5,347	49	5,807	51,303	51,303	31.00
41.00	04100	SUBPROVIDER - IRF	5,717	63	19,431	38,302	38,302	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,307	56	16,732	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,838	122	0	80,874	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,285	16	0	41,962	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	592	5	0	11,084	0	55.00
57.00	05700	CT SCAN	0	0	0	6,259	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	2,364	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1	0	4,776	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,888	0	0	19,126	0	59.00
60.00	06000	LABORATORY	0	35	0	79,108	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3	0	27,210	0	65.00
66.00	06600	PHYSICAL THERAPY	617	4	0	68,788	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	628	35	0	18,137	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	54	20	0	17,991	0	76.01
76.02	03070	WOMEN'S CENTER	365	22	0	13,169	0	76.02
76.03	03330	ENDOSCOPY	3,264	0	0	12,451	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	99	0	0	17,951	0	90.00
90.01	09001	OUTPATIENT	1,988	12	0	11,425	0	90.01
91.00	09100	EMERGENCY	9,877	85	0	48,318	48,318	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	2,435	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,352	902	82,196	893,600	337,350	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3	0	4,401	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,772	53	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	5,838	0	192.01
192.02	19202	CLINICS	26	20	0	0	0	192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0	0	192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0	0	192.04
192.05	19203	PRACTICE MANAGEMENT	24	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	WORKMED	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	3,665	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	543,983	1,899,782	1,094,483	1,741,740	1,066,182	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.434102	1,942.517382	13.315526	1.919264	3.160462	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,740	66,770	136,346	274,928	12,221	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.199060	68.271984	1.658791	0.302950	0.036226	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
			14.00	15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	615			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	5,320		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	205	4,154		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	36	325		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	455		41.00
43.00	04300	NURSERY	0	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1	386		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	212	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	8	0		55.00
57.00	05700	CT SCAN	0	0	0	0		57.00
57.01	03630	ULTRA SOUND	0	0	0	0		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	0	11	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	59	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	22	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0		76.00
76.01	03140	CARDIAC REHAB	0	0	0	0		76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0		76.02
76.03	03330	ENDOSCOPY	0	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	OUTPATIENT	0	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	53	0		91.00
91.01	09101	SHORT STAY	0	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	611	5,320		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	FOUNDATION	0	0	0	0		192.01
192.02	19202	CLINICS	0	0	4	0		192.02
192.03	19206	HOME HEALTH PARTNERSHIP	0	0	0	0		192.03
192.04	19207	WESTFIELD SCHOOLS	0	0	0	0		192.04
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0		192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0		192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0		192.08
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	WORKMED	0	0	0	0		194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0		194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 3:36 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
			14.00	15.00	16.00	17.00		
202.00		Cost to be allocated (per Wkst. B, Part I)	16,689,215	12,301,901	1,779,061	1,064,709		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	166,892.150000	123,019.010000	2,892.782114	200.133271		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	280,863	351,942	151,864	80,443		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2,808.630000	3,519.420000	246.933333	15.120865		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 3:36 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,095,673		18,095,673	0	18,095,673	30.00
31.00	03100	INTENSIVE CARE UNIT	4,290,862		4,290,862	0	4,290,862	31.00
41.00	04100	SUBPROVIDER - IRF	4,216,436		4,216,436	0	4,216,436	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,409,963		3,409,963	0	3,409,963	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,511,820		9,511,820	0	9,511,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,965,835		3,965,835	0	3,965,835	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,544,540		1,544,540	0	1,544,540	55.00
57.00	05700	CT SCAN	342,315		342,315	0	342,315	57.00
57.01	03630	ULTRA SOUND	219,698		219,698	0	219,698	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	250,763		250,763	0	250,763	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,349,298		1,349,298	0	1,349,298	59.00
60.00	06000	LABORATORY	7,131,204		7,131,204	0	7,131,204	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	978,416		978,416	0	978,416	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,621,623	0	1,621,623	0	1,621,623	65.00
66.00	06600	PHYSICAL THERAPY	6,556,197	0	6,556,197	0	6,556,197	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	1,948,133		1,948,133	0	1,948,133	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,689,215		16,689,215	0	16,689,215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,280,599		1,280,599	0	1,280,599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,301,901		12,301,901	0	12,301,901	73.00
74.00	07400	RENAL DIALYSIS	349,875		349,875	0	349,875	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	1,069,683		1,069,683	0	1,069,683	76.01
76.02	03070	WOMEN'S CENTER	1,145,668		1,145,668	0	1,145,668	76.02
76.03	03330	ENDOSCOPY	842,893		842,893	0	842,893	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,943,118		1,943,118	0	1,943,118	90.00
90.01	09001	OUTPATIENT	1,254,267		1,254,267	0	1,254,267	90.01
91.00	09100	EMERGENCY	4,907,618		4,907,618	0	4,907,618	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,262,106		2,262,106		2,262,106	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	86,761		86,761	0	86,761	95.00
200.00		Subtotal (see instructions)	109,566,480	0	109,566,480	0	109,566,480	200.00
201.00		Less Observation Beds	2,262,106		2,262,106		2,262,106	201.00
202.00		Total (see instructions)	107,304,374	0	107,304,374	0	107,304,374	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 3:36 pm

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		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	24,491,005		24,491,005			30.00
31.00	03100	INTENSIVE CARE UNIT	5,895,771		5,895,771			31.00
41.00	04100	SUBPROVIDER - IRF	5,747,163		5,747,163			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	2,456,021		2,456,021			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,324,249	22,838,848	42,163,097	0.225596	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,678,736	12,364,856	14,043,592	0.282395	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	168,591	5,268,430	5,437,021	0.284078	0.000000	55.00
57.00	05700	CT SCAN	1,637,085	7,988,294	9,625,379	0.035564	0.000000	57.00
57.01	03630	ULTRA SOUND	271,615	2,150,702	2,422,317	0.090697	0.000000	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	357,048	3,085,796	3,442,844	0.072836	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,662,545	7,929,162	12,591,707	0.107158	0.000000	59.00
60.00	06000	LABORATORY	10,793,232	25,531,470	36,324,702	0.196318	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,054,210	605,044	1,659,254	0.589672	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,870,847	991,027	5,861,874	0.276639	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,476,718	9,977,651	17,454,369	0.375619	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,849,487	7,843,806	9,693,293	0.200977	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,521,441	19,075,896	43,597,337	0.382804	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,595,222	2,726,120	4,321,342	0.296343	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,767,395	9,664,215	21,431,610	0.574007	0.000000	73.00
74.00	07400	RENAL DIALYSIS	414,926	2,860	417,786	0.837450	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	324,525	2,633,058	2,957,583	0.361675	0.000000	76.01
76.02	03070	WOMEN'S CENTER	8,613	4,055,284	4,063,897	0.281914	0.000000	76.02
76.03	03330	ENDOSCOPY	912,493	4,884,464	5,796,957	0.145403	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,048	3,799,418	3,803,466	0.510881	0.000000	90.00
90.01	09001	OUTPATIENT	179,109	3,978,413	4,157,522	0.301686	0.000000	90.01
91.00	09100	EMERGENCY	2,947,880	18,383,279	21,331,159	0.230068	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	557,582	2,319,575	2,877,157	0.786230	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	135,967,557	178,097,668	314,065,225			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	135,967,557	178,097,668	314,065,225			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 3:36 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.225596	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282395	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.284078	55.00
57.00	05700	CT SCAN	0.035564	57.00
57.01	03630	ULTRA SOUND	0.090697	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072836	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.107158	59.00
60.00	06000	LABORATORY	0.196318	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.589672	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.276639	65.00
66.00	06600	PHYSICAL THERAPY	0.375619	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200977	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382804	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.296343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.574007	73.00
74.00	07400	RENAL DIALYSIS	0.837450	74.00
76.00	03020	OTHER ANCILLARY	0.000000	76.00
76.01	03140	CARDIAC REHAB	0.361675	76.01
76.02	03070	WOMEN'S CENTER	0.281914	76.02
76.03	03330	ENDOSCOPY	0.145403	76.03
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.510881	90.00
90.01	09001	OUTPATIENT	0.301686	90.01
91.00	09100	EMERGENCY	0.230068	91.00
91.01	09101	SHORT STAY	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.786230	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 3:36 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	18,095,673		18,095,673	0	18,095,673	30.00
31.00	03100	INTENSIVE CARE UNIT	4,290,862		4,290,862	0	4,290,862	31.00
41.00	04100	SUBPROVIDER - IRF	4,216,436		4,216,436	0	4,216,436	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,409,963		3,409,963	0	3,409,963	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,511,820		9,511,820	0	9,511,820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,965,835		3,965,835	0	3,965,835	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,544,540		1,544,540	0	1,544,540	55.00
57.00	05700	CT SCAN	342,315		342,315	0	342,315	57.00
57.01	03630	ULTRA SOUND	219,698		219,698	0	219,698	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	250,763		250,763	0	250,763	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,349,298		1,349,298	0	1,349,298	59.00
60.00	06000	LABORATORY	7,131,204		7,131,204	0	7,131,204	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	978,416		978,416	0	978,416	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,621,623	0	1,621,623	0	1,621,623	65.00
66.00	06600	PHYSICAL THERAPY	6,556,197	0	6,556,197	0	6,556,197	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	1,948,133		1,948,133	0	1,948,133	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,689,215		16,689,215	0	16,689,215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,280,599		1,280,599	0	1,280,599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,301,901		12,301,901	0	12,301,901	73.00
74.00	07400	RENAL DIALYSIS	349,875		349,875	0	349,875	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03140	CARDIAC REHAB	1,069,683		1,069,683	0	1,069,683	76.01
76.02	03070	WOMEN'S CENTER	1,145,668		1,145,668	0	1,145,668	76.02
76.03	03330	ENDOSCOPY	842,893		842,893	0	842,893	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,943,118		1,943,118	0	1,943,118	90.00
90.01	09001	OUTPATIENT	1,254,267		1,254,267	0	1,254,267	90.01
91.00	09100	EMERGENCY	4,907,618		4,907,618	0	4,907,618	91.00
91.01	09101	SHORT STAY	0		0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,262,106		2,262,106		2,262,106	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	86,761		86,761	0	86,761	95.00
200.00		Subtotal (see instructions)	109,566,480	0	109,566,480	0	109,566,480	200.00
201.00		Less Observation Beds	2,262,106		2,262,106		2,262,106	201.00
202.00		Total (see instructions)	107,304,374	0	107,304,374	0	107,304,374	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 3:36 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	24,491,005		24,491,005			30.00
31.00	03100	INTENSIVE CARE UNIT	5,895,771		5,895,771			31.00
41.00	04100	SUBPROVIDER - IRF	5,747,163		5,747,163			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	2,456,021		2,456,021			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,324,249	22,838,848	42,163,097	0.225596	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,678,736	12,364,856	14,043,592	0.282395	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	168,591	5,268,430	5,437,021	0.284078	0.000000	55.00
57.00	05700	CT SCAN	1,637,085	7,988,294	9,625,379	0.035564	0.000000	57.00
57.01	03630	ULTRA SOUND	271,615	2,150,702	2,422,317	0.090697	0.000000	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	357,048	3,085,796	3,442,844	0.072836	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,662,545	7,929,162	12,591,707	0.107158	0.000000	59.00
60.00	06000	LABORATORY	10,793,232	25,531,470	36,324,702	0.196318	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,054,210	605,044	1,659,254	0.589672	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,870,847	991,027	5,861,874	0.276639	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,476,718	9,977,651	17,454,369	0.375619	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,849,487	7,843,806	9,693,293	0.200977	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,521,441	19,075,896	43,597,337	0.382804	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,595,222	2,726,120	4,321,342	0.296343	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,767,395	9,664,215	21,431,610	0.574007	0.000000	73.00
74.00	07400	RENAL DIALYSIS	414,926	2,860	417,786	0.837450	0.000000	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03140	CARDIAC REHAB	324,525	2,633,058	2,957,583	0.361675	0.000000	76.01
76.02	03070	WOMEN'S CENTER	8,613	4,055,284	4,063,897	0.281914	0.000000	76.02
76.03	03330	ENDOSCOPY	912,493	4,884,464	5,796,957	0.145403	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,048	3,799,418	3,803,466	0.510881	0.000000	90.00
90.01	09001	OUTPATIENT	179,109	3,978,413	4,157,522	0.301686	0.000000	90.01
91.00	09100	EMERGENCY	2,947,880	18,383,279	21,331,159	0.230068	0.000000	91.00
91.01	09101	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	557,582	2,319,575	2,877,157	0.786230	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	135,967,557	178,097,668	314,065,225			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	135,967,557	178,097,668	314,065,225			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 3:36 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
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		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
57.00	05700	CT SCAN	0.000000		57.00
57.01	03630	ULTRA SOUND	0.000000		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	OTHER ANCILLARY	0.000000		76.00
76.01	03140	CARDIAC REHAB	0.000000		76.01
76.02	03070	WOMEN'S CENTER	0.000000		76.02
76.03	03330	ENDOSCOPY	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OUTPATIENT	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
91.01	09101	SHORT STAY	0.000000		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,647,051	0	3,647,051	14,599	249.82	30.00
31.00	INTENSIVE CARE UNIT	689,295		689,295	2,762	249.56	31.00
41.00	SUBPROVIDER - IRF	657,617	0	657,617	5,548	118.53	41.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	457,080		457,080	4,820	94.83	44.00
200.00	Total (lines 30-199)	5,451,043		5,451,043	27,729		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	5,221	1,304,310	30.00
31.00	INTENSIVE CARE UNIT	1,371	342,147	31.00
41.00	SUBPROVIDER - IRF	3,630	430,264	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,349	317,586	44.00
200.00	Total (lines 30-199)	13,571	2,394,307	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,355,378	42,163,097	0.032146	8,758,529	281,552	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	578,651	14,043,592	0.041204	905,447	37,308	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	318,281	5,437,021	0.058540	136,583	7,996	55.00
57.00	05700	CT SCAN	4,371	9,625,379	0.000454	819,822	372	57.00
57.01	03630	ULTRA SOUND	2,332	2,422,317	0.000963	112,390	108	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,308	3,442,844	0.000961	137,832	132	58.00
59.00	05900	CARDIAC CATHETERIZATION	139,827	12,591,707	0.011105	1,243,103	13,805	59.00
60.00	06000	LABORATORY	600,020	36,324,702	0.016518	4,758,129	78,595	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	166,789	1,659,254	0.100520	338,587	34,035	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	98,301	5,861,874	0.016770	2,583,938	43,333	65.00
66.00	06600	PHYSICAL THERAPY	82,585	17,454,369	0.004731	848,519	4,014	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	481,406	9,693,293	0.049664	953,107	47,335	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	280,863	43,597,337	0.006442	9,869,681	63,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,768	4,321,342	0.002029	780,978	1,585	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	351,942	21,431,610	0.016422	4,531,129	74,410	73.00
74.00	07400	RENAL DIALYSIS	24,932	417,786	0.059676	164,177	9,797	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	14,324	2,957,583	0.004843	178,109	863	76.01
76.02	03070	WOMEN'S CENTER	358,943	4,063,897	0.088325	3,250	287	76.02
76.03	03330	ENDOSCOPY	120,901	5,796,957	0.020856	41,963	875	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,712	3,803,466	0.005183	2,994	16	90.00
90.01	09001	OUTPATIENT	161,420	4,157,522	0.038826	127,087	4,934	90.01
91.00	09100	EMERGENCY	758,051	21,331,159	0.035537	1,638,223	58,218	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	455,912	2,877,157	0.158459	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	6,387,017	275,475,265		38,933,577	763,150	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,599	0.00	5,221	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,762	0.00	1,371	0		31.00
41.00	04100	SUBPROVIDER - IRF	5,548	0.00	3,630	0		41.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	4,820	0.00	3,349	0		44.00
200.00		Total (lines 30-199)	27,729		13,571	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,163,097	0.000000	0.000000	8,758,529	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,043,592	0.000000	0.000000	905,447	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,437,021	0.000000	0.000000	136,583	55.00
57.00	05700	CT SCAN	0	9,625,379	0.000000	0.000000	819,822	57.00
57.01	03630	ULTRA SOUND	0	2,422,317	0.000000	0.000000	112,390	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,442,844	0.000000	0.000000	137,832	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	12,591,707	0.000000	0.000000	1,243,103	59.00
60.00	06000	LABORATORY	0	36,324,702	0.000000	0.000000	4,758,129	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,659,254	0.000000	0.000000	338,587	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,861,874	0.000000	0.000000	2,583,938	65.00
66.00	06600	PHYSICAL THERAPY	0	17,454,369	0.000000	0.000000	848,519	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,693,293	0.000000	0.000000	953,107	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,597,337	0.000000	0.000000	9,869,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,321,342	0.000000	0.000000	780,978	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,431,610	0.000000	0.000000	4,531,129	73.00
74.00	07400	RENAL DIALYSIS	0	417,786	0.000000	0.000000	164,177	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03140	CARDIAC REHAB	0	2,957,583	0.000000	0.000000	178,109	76.01
76.02	03070	WOMEN'S CENTER	0	4,063,897	0.000000	0.000000	3,250	76.02
76.03	03330	ENDOSCOPY	0	5,796,957	0.000000	0.000000	41,963	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,803,466	0.000000	0.000000	2,994	90.00
90.01	09001	OUTPATIENT	0	4,157,522	0.000000	0.000000	127,087	90.01
91.00	09100	EMERGENCY	0	21,331,159	0.000000	0.000000	1,638,223	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,877,157	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	275,475,265			38,933,577	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,763,884	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,524,656	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,012,224	0		55.00
57.00	05700	CT SCAN	0	2,719,975	0		57.00
57.01	03630	ULTRA SOUND	0	366,344	0		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	909,956	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,373,081	0		59.00
60.00	06000	LABORATORY	0	2,839,920	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	243,211	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	891,054	0		65.00
66.00	06600	PHYSICAL THERAPY	0	420	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	1,983,852	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,707,418	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	992,668	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,222,717	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0	0		76.00
76.01	03140	CARDIAC REHAB	0	1,104,341	0		76.01
76.02	03070	WOMEN'S CENTER	0	296,304	0		76.02
76.03	03330	ENDOSCOPY	0	154,806	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,037,628	0		90.00
90.01	09001	OUTPATIENT	0	820,179	0		90.01
91.00	09100	EMERGENCY	0	3,089,130	0		91.00
91.01	09101	SHORT STAY	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	795,869	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	38,849,637	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.225596	4,763,884	0	0	1,074,713	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282395	3,524,656	0	0	995,345	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.284078	2,012,224	0	0	571,629	55.00
57.00	05700	CT SCAN	0.035564	2,719,975	0	0	96,733	57.00
57.01	03630	ULTRA SOUND	0.090697	366,344	0	0	33,226	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072836	909,956	0	267	66,278	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.107158	3,373,081	0	0	361,453	59.00
60.00	06000	LABORATORY	0.196318	2,839,920	0	0	557,527	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.589672	243,211	0	0	143,415	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.276639	891,054	0	0	246,500	65.00
66.00	06600	PHYSICAL THERAPY	0.375619	420	0	0	158	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200977	1,983,852	0	0	398,709	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382804	4,707,418	0	1,297	1,802,018	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.296343	992,668	0	0	294,170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.574007	2,222,717	0	10,319	1,275,855	73.00
74.00	07400	RENAL DIALYSIS	0.837450	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0.361675	1,104,341	0	0	399,413	76.01
76.02	03070	WOMEN'S CENTER	0.281914	296,304	0	0	83,532	76.02
76.03	03330	ENDOSCOPY	0.145403	154,806	0	0	22,509	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.510881	1,037,628	0	77	530,104	90.00
90.01	09001	OUTPATIENT	0.301686	820,179	0	2,089	247,437	90.01
91.00	09100	EMERGENCY	0.230068	3,089,130	0	0	710,710	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.786230	795,869	0	0	625,736	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		38,849,637	0	14,049	10,537,170	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		38,849,637	0	14,049	10,537,170	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	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
57.00	05700	CT SCAN	0	0		57.00
57.01	03630	ULTRA SOUND	0	0		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	496		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,923		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0		76.00
76.01	03140	CARDIAC REHAB	0	0		76.01
76.02	03070	WOMEN'S CENTER	0	0		76.02
76.03	03330	ENDOSCOPY	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	39		90.00
90.01	09001	OUTPATIENT	0	630		90.01
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	SHORT STAY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	7,107		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	7,107		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150059 | Component CCN: 15T059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,355,378	42,163,097	0.032146	84,928	2,730	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	578,651	14,043,592	0.041204	68,052	2,804	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	318,281	5,437,021	0.058540	28,313	1,657	55.00
57.00	05700	CT SCAN	4,371	9,625,379	0.000454	63,947	29	57.00
57.01	03630	ULTRA SOUND	2,332	2,422,317	0.000963	5,701	5	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,308	3,442,844	0.000961	23,338	22	58.00
59.00	05900	CARDIAC CATHETERIZATION	139,827	12,591,707	0.011105	25,398	282	59.00
60.00	06000	LABORATORY	600,020	36,324,702	0.016518	638,239	10,542	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	166,789	1,659,254	0.100520	14,817	1,489	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	98,301	5,861,874	0.016770	414,535	6,952	65.00
66.00	06600	PHYSICAL THERAPY	82,585	17,454,369	0.004731	3,028,151	14,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	481,406	9,693,293	0.049664	51,750	2,570	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	280,863	43,597,337	0.006442	381,029	2,455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	8,768	4,321,342	0.002029	12,508	25	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	351,942	21,431,610	0.016422	715,500	11,750	73.00
74.00	07400	RENAL DIALYSIS	24,932	417,786	0.059676	108,691	6,486	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	14,324	2,957,583	0.004843	9,781	47	76.01
76.02	03070	WOMEN'S CENTER	358,943	4,063,897	0.088325	47	4	76.02
76.03	03330	ENDOSCOPY	120,901	5,796,957	0.020856	1,074	22	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,712	3,803,466	0.005183	61	0	90.00
90.01	09001	OUTPATIENT	161,420	4,157,522	0.038826	15,565	604	90.01
91.00	09100	EMERGENCY	758,051	21,331,159	0.035537	50,354	1,789	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,877,157	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,931,105	275,475,265		5,741,779	66,590	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059 | Component CCN: 15T059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059 | Component CCN: 15T059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,163,097	0.000000	0.000000	84,928	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,043,592	0.000000	0.000000	68,052	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,437,021	0.000000	0.000000	28,313	55.00
57.00	05700	CT SCAN	0	9,625,379	0.000000	0.000000	63,947	57.00
57.01	03630	ULTRA SOUND	0	2,422,317	0.000000	0.000000	5,701	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,442,844	0.000000	0.000000	23,338	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	12,591,707	0.000000	0.000000	25,398	59.00
60.00	06000	LABORATORY	0	36,324,702	0.000000	0.000000	638,239	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,659,254	0.000000	0.000000	14,817	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,861,874	0.000000	0.000000	414,535	65.00
66.00	06600	PHYSICAL THERAPY	0	17,454,369	0.000000	0.000000	3,028,151	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,693,293	0.000000	0.000000	51,750	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,597,337	0.000000	0.000000	381,029	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,321,342	0.000000	0.000000	12,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,431,610	0.000000	0.000000	715,500	73.00
74.00	07400	RENAL DIALYSIS	0	417,786	0.000000	0.000000	108,691	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03140	CARDIAC REHAB	0	2,957,583	0.000000	0.000000	9,781	76.01
76.02	03070	WOMEN'S CENTER	0	4,063,897	0.000000	0.000000	47	76.02
76.03	03330	ENDOSCOPY	0	5,796,957	0.000000	0.000000	1,074	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,803,466	0.000000	0.000000	61	90.00
90.01	09001	OUTPATIENT	0	4,157,522	0.000000	0.000000	15,565	90.01
91.00	09100	EMERGENCY	0	21,331,159	0.000000	0.000000	50,354	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,877,157	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	275,475,265			5,741,779	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059 | Component CCN: 15T059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
57.00	05700	CT SCAN	0	0	0		57.00
57.01	03630	ULTRA SOUND	0	0	0		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0	0		76.00
76.01	03140	CARDIAC REHAB	0	0	0		76.01
76.02	03070	WOMEN'S CENTER	0	0	0		76.02
76.03	03330	ENDOSCOPY	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OUTPATIENT	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
91.01	09101	SHORT STAY	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059 | Component CCN: 155669 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03140	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03070	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059 | Component CCN: 155669 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,163,097	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,043,592	0.000000	0.000000	57,052	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,437,021	0.000000	0.000000	0	55.00
57.00	05700	CT SCAN	0	9,625,379	0.000000	0.000000	0	57.00
57.01	03630	ULTRA SOUND	0	2,422,317	0.000000	0.000000	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,442,844	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	12,591,707	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	36,324,702	0.000000	0.000000	806,146	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,659,254	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,861,874	0.000000	0.000000	217,650	65.00
66.00	06600	PHYSICAL THERAPY	0	17,454,369	0.000000	0.000000	896,712	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,693,293	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,597,337	0.000000	0.000000	48,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,321,342	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,431,610	0.000000	0.000000	992,516	73.00
74.00	07400	RENAL DIALYSIS	0	417,786	0.000000	0.000000	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03140	CARDIAC REHAB	0	2,957,583	0.000000	0.000000	26,132	76.01
76.02	03070	WOMEN'S CENTER	0	4,063,897	0.000000	0.000000	0	76.02
76.03	03330	ENDOSCOPY	0	5,796,957	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,803,466	0.000000	0.000000	0	90.00
90.01	09001	OUTPATIENT	0	4,157,522	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	21,331,159	0.000000	0.000000	0	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,877,157	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	275,475,265			3,044,210	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059 | Component CCN: 155669 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
57.00	05700	CT SCAN	0	0	0		57.00
57.01	03630	ULTRA SOUND	0	0	0		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	OTHER ANCILLARY	0	0	0		76.00
76.01	03140	CARDIAC REHAB	0	0	0		76.01
76.02	03070	WOMEN'S CENTER	0	0	0		76.02
76.03	03330	ENDOSCOPY	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OUTPATIENT	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
91.01	09101	SHORT STAY	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,599	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,599	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)	12,774	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,221	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	18,095,673	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	18,095,673	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)	18,095,673	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)	1,239.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,471,482	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	6,471,482	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,290,862	2,762	1,553.53	1,371	2,129,890	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)	12,048,020	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	20,649,392	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,646,457	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	763,150	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,409,607	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	18,239,785	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,825	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,239.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,262,106	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,647,051	18,095,673	0.201543	2,262,106	455,912	90.00
91.00	Nursing School cost	0	18,095,673	0.000000	2,262,106	0	91.00
92.00	Allied health cost	0	18,095,673	0.000000	2,262,106	0	92.00
93.00	All other Medical Education	0	18,095,673	0.000000	2,262,106	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,548	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,548	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)	5,548	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,630	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,216,436	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,216,436	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,216,436	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)	759.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,758,764	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)	2,758,764	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 15T059 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,121,487	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,880,251	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)	430,264	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	66,590	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	496,854	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,383,397	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 15T059 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	657,617	4,216,436	0.155965	0	0	90.00
91.00	Nursing School cost	0	4,216,436	0.000000	0	0	91.00
92.00	Allied health cost	0	4,216,436	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,216,436	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,820	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,820	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,820	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,349	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,409,963	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,409,963	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)	3,409,963	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150059 | Component CCN: 155669 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,409,963	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	707.46	71.00
72.00	Program routine service cost (line 9 x line 71)	2,369,284	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,369,284	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,369,284	83.00
84.00	Program inpatient ancillary services (see instructions)	1,168,941	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,538,225	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: 150059 Component CCN: 155669	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XIX | 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)	14,599	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,599	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)	12,774	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	703	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	18,095,673	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	18,095,673	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)	18,095,673	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)	1,239.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	871,376	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)	871,376	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XIX | 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	4,290,862	2,762	1,553.53	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,045,708	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,917,084	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,825	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,239.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,262,106	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XIX | 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	3,647,051	18,095,673	0.201543	2,262,106	455,912	90.00
91.00	Nursing School cost	0	18,095,673	0.000000	2,262,106	0	91.00
92.00	Allied health cost	0	18,095,673	0.000000	2,262,106	0	92.00
93.00	All other Medical Education	0	18,095,673	0.000000	2,262,106	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 3:36 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,548	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,548	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)	5,548	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	266	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,216,436	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,216,436	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,216,436	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)	759.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	202,157	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)	202,157	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150059 | Component CCN: 15T059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XIX | Subprovider - IRF | 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	186,714	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	388,871	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 15T059 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XIX | Subprovider - IRF | 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	657,617	4,216,436	0.155965	0	0	90.00
91.00	Nursing School cost	0	4,216,436	0.000000	0	0	91.00
92.00	Allied health cost	0	4,216,436	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,216,436	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,706,855		30.00
31.00	03100	INTENSIVE CARE UNIT		2,957,854		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.225596	8,758,529	1,975,889	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282395	905,447	255,694	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.284078	136,583	38,800	55.00
57.00	05700	CT SCAN	0.035564	819,822	29,156	57.00
57.01	03630	ULTRA SOUND	0.090697	112,390	10,193	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072836	137,832	10,039	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.107158	1,243,103	133,208	59.00
60.00	06000	LABORATORY	0.196318	4,758,129	934,106	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.589672	338,587	199,655	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.276639	2,583,938	714,818	65.00
66.00	06600	PHYSICAL THERAPY	0.375619	848,519	318,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200977	953,107	191,553	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382804	9,869,681	3,778,153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.296343	780,978	231,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.574007	4,531,129	2,600,900	73.00
74.00	07400	RENAL DIALYSIS	0.837450	164,177	137,490	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.361675	178,109	64,418	76.01
76.02	03070	WOMEN'S CENTER	0.281914	3,250	916	76.02
76.03	03330	ENDOSCOPY	0.145403	41,963	6,102	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.510881	2,994	1,530	90.00
90.01	09001	OUTPATIENT	0.301686	127,087	38,340	90.01
91.00	09100	EMERGENCY	0.230068	1,638,223	376,903	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.786230	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		38,933,577	12,048,020	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)		38,933,577		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150059 | Component CCN: 15T059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		3,786,744		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.225596	84,928	19,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282395	68,052	19,218	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.284078	28,313	8,043	55.00
57.00	05700	CT SCAN	0.035564	63,947	2,274	57.00
57.01	03630	ULTRA SOUND	0.090697	5,701	517	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072836	23,338	1,700	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.107158	25,398	2,722	59.00
60.00	06000	LABORATORY	0.196318	638,239	125,298	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.589672	14,817	8,737	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.276639	414,535	114,677	65.00
66.00	06600	PHYSICAL THERAPY	0.375619	3,028,151	1,137,431	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200977	51,750	10,401	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382804	381,029	145,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.296343	12,508	3,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.574007	715,500	410,702	73.00
74.00	07400	RENAL DIALYSIS	0.837450	108,691	91,023	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.361675	9,781	3,538	76.01
76.02	03070	WOMEN'S CENTER	0.281914	47	13	76.02
76.03	03330	ENDOSCOPY	0.145403	1,074	156	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.510881	61	31	90.00
90.01	09001	OUTPATIENT	0.301686	15,565	4,696	90.01
91.00	09100	EMERGENCY	0.230068	50,354	11,585	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.786230	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		5,741,779	2,121,487	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		5,741,779		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150059 | Component CCN: 155669 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.225596	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282395	57,052	16,111	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.284078	0	0	55.00
57.00	05700	CT SCAN	0.035564	0	0	57.00
57.01	03630	ULTRA SOUND	0.090697	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072836	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.107158	0	0	59.00
60.00	06000	LABORATORY	0.196318	806,146	158,261	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.589672	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.276639	217,650	60,210	65.00
66.00	06600	PHYSICAL THERAPY	0.375619	896,712	336,822	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200977	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382804	48,002	18,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.296343	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.574007	992,516	569,711	73.00
74.00	07400	RENAL DIALYSIS	0.837450	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.361675	26,132	9,451	76.01
76.02	03070	WOMEN'S CENTER	0.281914	0	0	76.02
76.03	03330	ENDOSCOPY	0.145403	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.510881	0	0	90.00
90.01	09001	OUTPATIENT	0.301686	0	0	90.01
91.00	09100	EMERGENCY	0.230068	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.786230	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,044,210	1,168,941	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)		3,044,210		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 3:36 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		866,092		30.00
31.00	03100	INTENSIVE CARE UNIT		391,261		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.225596	412,334	93,021	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282395	75,582	21,344	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.284078	0	0	55.00
57.00	05700	CT SCAN	0.035564	71,692	2,550	57.00
57.01	03630	ULTRA SOUND	0.090697	20,801	1,887	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072836	16,704	1,217	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.107158	136,685	14,647	59.00
60.00	06000	LABORATORY	0.196318	500,870	98,330	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.589672	38,300	22,584	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.276639	401,456	111,058	65.00
66.00	06600	PHYSICAL THERAPY	0.375619	41,159	15,460	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200977	51,294	10,309	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382804	702,812	269,039	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.296343	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.574007	586,325	336,555	73.00
74.00	07400	RENAL DIALYSIS	0.837450	3,647	3,054	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.361675	10,179	3,681	76.01
76.02	03070	WOMEN'S CENTER	0.281914	0	0	76.02
76.03	03330	ENDOSCOPY	0.145403	39,990	5,815	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.510881	120	61	90.00
90.01	09001	OUTPATIENT	0.301686	13,506	4,075	90.01
91.00	09100	EMERGENCY	0.230068	134,832	31,021	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.786230	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,258,288	1,045,708	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)		3,258,288		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 15T059 | Date/Time Prepared: 5/27/2015 3:36 pm

Title XIX | Subprovider - IRF | 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
41.00	04100	SUBPROVIDER - IRF		295,937		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.225596	22,649	5,110	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282395	10,115	2,856	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.284078	0	0	55.00
57.00	05700	CT SCAN	0.035564	5,581	198	57.00
57.01	03630	ULTRA SOUND	0.090697	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.072836	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.107158	0	0	59.00
60.00	06000	LABORATORY	0.196318	52,425	10,292	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.589672	1,011	596	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.276639	71,344	19,737	65.00
66.00	06600	PHYSICAL THERAPY	0.375619	224,656	84,385	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.200977	1,927	387	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.382804	53,163	20,351	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.296343	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.574007	71,046	40,781	73.00
74.00	07400	RENAL DIALYSIS	0.837450	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03140	CARDIAC REHAB	0.361675	0	0	76.01
76.02	03070	WOMEN'S CENTER	0.281914	0	0	76.02
76.03	03330	ENDOSCOPY	0.145403	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.510881	0	0	90.00
90.01	09001	OUTPATIENT	0.301686	6,699	2,021	90.01
91.00	09100	EMERGENCY	0.230068	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.786230	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		520,616	186,714	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)		520,616		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Hospital	PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		10,895,883		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,886,164		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		215,862		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		100.00		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.39		30.00
31.00	Percentage of Medicaid patient days (see instructions)		13.94		31.00
32.00	Sum of lines 30 and 31		16.33		32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.37		33.00
34.00	Disproportionate share adjustment (see instructions)		124,539		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000094264	0.000086639	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		852,745	662,586	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		637,806	167,008	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		804,814		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		15,927,262		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		15,927,262		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,272,505		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		17,199,767		59.00
60.00	Primary payer payments		13,409		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		17,186,358		61.00
62.00	Deductibles billed to program beneficiaries		1,471,904		62.00
63.00	Coinsurance billed to program beneficiaries		37,088		63.00
64.00	Allowable bad debts (see instructions)		61,488		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		39,967		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		-20,753		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,717,333		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-27,801		70.93
70.94	HRR adjustment amount (see instructions)		0		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,689,532		71.00
71.01	Sequestration adjustment (see instructions)		313,791		71.01
72.00	Interim payments		15,220,490		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		155,251		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,573,313		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	10,895,883	3,886,164	14,782,047	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,895,883	0	10,895,883	0	10,895,883	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,886,164	0	0	3,886,164	3,886,164	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	215,862	0	179,872	35,990	215,862	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	3,057,095	863,063	3,920,158	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0337	0.0337	0.0337	0.0337		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	124,539	0	91,798	32,741	124,539	11.00
11.01	Uncompensated care payments	36.00	804,814	0	637,806	167,008	804,814	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,927,262	0	7,919,195	8,008,067	15,927,262	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,927,262	0	7,919,195	8,008,067	15,927,262	15.00
16.00	Payment for inpatient program capital	50.00	1,272,505	0	942,703	329,802	1,272,505	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	8,861,898	8,337,869	17,199,767	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,181,769	0	870,927	310,843	1,181,770	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	50,910	0	42,426	8,484	50,910	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0337	0.0337	0.0337	0.0337		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	39,826	0	29,351	10,475	39,826	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,272,505	0	942,703	329,802	1,272,505	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,895,883	10,895,883		10,895,883	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,886,164		3,886,164	3,886,164	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	215,862	179,872	35,990	215,862	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0337	0.0337	0.0337		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	124,539	91,798	32,741	124,539	11.00
11.01	Uncompensated care payments	36.00	804,814	637,806	167,008	804,814	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,927,262	11,805,359	4,121,903	15,927,262	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,927,262	11,805,359	4,121,903	15,927,262	15.00
16.00	Payment for inpatient program capital	50.00	1,272,505	942,703	329,802	1,272,505	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			12,748,062	4,451,705	17,199,767	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,181,769	870,926	310,843	1,181,769	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	50,910	42,426	8,484	50,910	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0337	0.0337	0.0337		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	39,826	29,351	10,475	39,826	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,272,505	942,703	329,802	1,272,505	26.00

		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-27,801	-14,315	-13,486	-27,801	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01

						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,107	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,537,170	2.00
3.00	PPS payments	9,431,389	3.00
4.00	Outlier payment (see instructions)	22,197	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)	7,107	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	14,049	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)	14,049	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)	14,049	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	6,942	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)	7,107	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	9,453,586	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	14	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,069,717	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	7,390,962	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)	7,390,962	30.00
31.00	Primary payer payments	2,598	31.00
32.00	Subtotal (line 30 minus line 31)	7,388,364	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)	171,644	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	111,569	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	86,821	36.00
37.00	Subtotal (see instructions)	7,499,933	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-121	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)	7,500,054	40.00
40.01	Sequestration adjustment (see instructions)	150,001	40.01
41.00	Interim payments	7,236,876	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	113,177	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 3:36 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		15,220,490		7,236,876	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15,220,490		7,236,876	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		155,251		113,177	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		15,375,741		7,350,053	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: 150059 Component CCN: 15T059	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part I Date/Time Prepared: 5/27/2015 3:36 pm
Title XVIII	Subprovider - IRF	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,945,338		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,945,338		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		45,805		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,991,143		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part I Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,647,100		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,647,100		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,647,100		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: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	3,810	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	6,592	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,708	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	15,536	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	314,065,225	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,957,481	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,027,630	8.00
9.00	Sequestration adjustment amount (see instructions)	20,553	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,007,077	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	865,765	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)	141,312	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	5,123,822	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0101	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	112,724	3.00
4.00	Outlier Payments	25,505	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	15.200000	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	5,262,051	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	5,262,051	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	5,262,051	19.00
20.00	Deductibles	89,856	20.00
21.00	Subtotal (line 19 minus line 20)	5,172,195	21.00
22.00	Coinsurance	79,192	22.00
23.00	Subtotal (line 21 minus line 22)	5,093,003	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	5,093,003	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	5,093,003	32.00
32.01	Sequestration adjustment (see instructions)	101,860	32.01
33.00	Interim payments	4,945,338	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	45,805	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	3,740,214	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	25,505	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VI Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,797,298	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,797,298	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	116,584	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,680,714	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	1,680,714	15.00
15.01	Sequestration adjustment (see instructions)	33,614	15.01
16.00	Interim payments	1,647,100	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2015 3:36 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,917,084		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	5		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,917,089	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,917,089	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,257,353		8.00
9.00	Ancillary service charges	3,258,288	0	9.00
10.00	Organ acquisition charges, net of revenue	5		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	4,515,646	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	4,515,646	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,598,557	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,917,089	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,917,089	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,917,089	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,917,089	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,917,089	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,917,089	0	40.00
41.00	Interim payments	2,009,901	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-92,812	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2015 3:36 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	388,871		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	388,871	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	388,871	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	295,937		8.00
9.00	Ancillary service charges	520,616	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	816,553	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	816,553	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	427,682	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	388,871	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	388,871	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	388,871	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	388,871	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	388,871	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	388,871	0	40.00
41.00	Interim payments	458,348	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-69,477	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/27/2015 3:36 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	8,832,191	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	20,699,262	0	0	0	4.00
5.00	Other receivable	192,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,228,533	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	20,445,545	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	53,397,531	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	15,917,384	0	0	0	12.00
13.00	Land improvements	6,134,813	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	199,994,008	0	0	0	15.00
16.00	Accumulated depreciation	-122,307,016	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	99,739,189	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	82,145,890	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,733,510	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	88,879,400	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	242,016,120	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,408,507	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,229,319	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,202,957	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	53,463,573	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	72,304,356	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	36,230,973	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	36,230,973	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	108,535,329	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	133,480,791				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)	133,480,791	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	242,016,120	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/27/2015 3:36 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		127,001,986		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,675,733				2.00
3.00	Total (sum of line 1 and line 2)		132,677,719		0		3.00
4.00	DEFERRED INFLOWS - INT. RATE SWAP	803,072		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)		803,072		0		10.00
11.00	Subtotal (line 3 plus line 10)		133,480,791		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)		133,480,791		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	DEFERRED INFLOWS - INT. RATE SWAP		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: 150059 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2015 3:36 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	24,491,005		24,491,005	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,747,163		5,747,163	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	2,456,021		2,456,021	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)	32,694,189		32,694,189	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,895,771		5,895,771	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)	5,895,771		5,895,771	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	38,589,960		38,589,960	17.00
18.00	Ancillary services	93,688,978	149,616,983	243,305,961	18.00
19.00	Outpatient services	3,688,619	28,480,685	32,169,304	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	0	3,561,453	3,561,453	27.00
27.01	PHYSICIAN OFFICES	72,130	46,797,594	46,869,724	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	136,039,687	228,456,715	364,496,402	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		164,652,561		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		164,652,561		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/27/2015 3:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	364,496,402	1.00
2.00	Less contractual allowances and discounts on patients' accounts	203,767,921	2.00
3.00	Net patient revenues (line 1 minus line 2)	160,728,481	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	164,652,561	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,924,080	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,300,765	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	8,299,048	24.00
25.00	Total other income (sum of lines 6-24)	9,599,813	25.00
26.00	Total (line 5 plus line 25)	5,675,733	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,675,733	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150059	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/27/2015 3:36 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,181,769	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	50,910	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	43.19	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.39	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	13.94	8.00
9.00	Sum of lines 7 and 8	16.33	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.37	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	39,826	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,272,505	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00