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: 151326	Period: From 09/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/27/2015 5:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/27/2015 Time: 5:05 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 UNION HOSPITAL CLINTON (151326) for the cost reporting period beginning 09/01/2014 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: 5:05 pm
zJNs97u8oCKJbx2ULtwXfVYHFvHqV0
Xf.290Y6zuuEhZjrAGYoxw0.9w9QJZ
1CJF0Fwubv0Y4Krd
PI: Date: 5/27/2015 Time: 5:05 pm
wsGmkYcHcVMDp.eHTNv.h9Q1iQIgg0
1:jm:08n3Yjlnbpt:3KG7RYTDvMlp6
9A1w0m3uab0:VpK4

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

Exec VP & CFO
Title

5/29/15
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	172,352	-99,982	0	324,719	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	18,645	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	190,997	-99,982	0	324,719	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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 5:00 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 SOUTH MAIN STREET	PO Box:			1.00
2.00	City: CLINTON	State: IN	Zip Code: 47842-	County: VERMILLION	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	UNION HOSPITAL CLINTON	151326	45460	1	03/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BEDS	15Z326	45460		03/01/2005	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 5:00 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 5:00 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151326	Period: From 09/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 5:00 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 5:00 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	41,432	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151326	Period: From 09/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 5:00 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	15H043	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: UNION HOSPITAL, INC.	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 1606 NORTH SEVENTH ST	PO Box:		142.00
143.00	City: TERRE HAUTE	State: IN	Zip Code: 47804	143.00

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	25,855	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151326	Period: From 09/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 5:00 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)	10/01/2014	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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 5:00 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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.	Y			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	03/17/2015	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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 5:00 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CAROLYN	CHAPLIN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3177137919	CCHAPLIN@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 5:00 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)	03/17/2015			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.		SENIOR 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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2015 5:00 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	19	2,318	16,392.00	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)		19	2,318	16,392.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	732	3,960.00	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						13.00
14.00	Total (see instructions)		25	3,050	20,352.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 5:00 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)	413	117	683			1.00
2.00	HMO and other (see instructions)	33	72				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	114	0	114			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	14			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	527	117	811			7.00
8.00	INTENSIVE CARE UNIT	89	12	165			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)	616	129	976	0.00	140.47	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	140.47	27.00
28.00	Observation Bed Days		0	295			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2015 5:00 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	176	47	313	1.00
2.00	HMO and other (see instructions)			9	28		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	176	47	313	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/27/2015 5:00 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)	0.307325	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	0	6.00
7.00	Medicaid cost (line 1 times line 6)	0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,239,585	0	1,239,585	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	380,955	0	380,955	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)	380,955	0	380,955	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?		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)	1,230,937	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	254,646	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	976,291	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	300,039	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	680,994	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	680,994	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 5:00 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		265,133	265,133	0	265,133	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		114,169	114,169	0	114,169	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	13,006	13,006	0	13,006	5.01
5.02	00550	DATA PROCESSING	0	239,566	239,566	0	239,566	5.02
5.03	00561	PURCHASING RECEIVING AND STORES	0	2,520	2,520	0	2,520	5.03
5.04	00570	ADMITTING	152,359	20,074	172,433	0	172,433	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	7,070	124,344	131,414	0	131,414	5.05
5.06	00590	OTHER ADMIN AND GENERAL	211,606	315,548	527,154	0	527,154	5.06
7.00	00700	OPERATION OF PLANT	120,360	189,541	309,901	0	309,901	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	976	976	0	976	8.00
9.00	00900	HOUSEKEEPING	75,057	26,922	101,979	0	101,979	9.00
10.00	01000	DIETARY	105,670	75,196	180,866	-135,189	45,677	10.00
11.00	01100	CAFETERIA	0	0	0	135,189	135,189	11.00
13.00	01300	NURSING ADMINISTRATION	178,426	30,290	208,716	0	208,716	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,374	31,131	89,505	0	89,505	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	507,269	83,056	590,325	0	590,325	30.00
31.00	03100	INTENSIVE CARE UNIT	227,076	28,311	255,387	0	255,387	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	101,348	263,774	365,122	0	365,122	50.00
51.00	05100	RECOVERY ROOM	23,335	1,753	25,088	0	25,088	51.00
51.01	05101	O/P TREATMENT ROOM	51,755	10,894	62,649	0	62,649	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,957	212,299	676,256	0	676,256	54.00
56.00	05600	RADIOISOTOPE	0	37,213	37,213	0	37,213	56.00
60.00	06000	LABORATORY	0	333,211	333,211	0	333,211	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	25,975	25,975	0	25,975	62.00
65.00	06500	RESPIRATORY THERAPY	108,370	36,220	144,590	0	144,590	65.00
66.00	06600	PHYSICAL THERAPY	0	312,325	312,325	0	312,325	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,164	2,164	0	2,164	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,314	8,314	0	8,314	68.00
69.00	06900	ELECTROCARDIOLOGY	34,778	19,634	54,412	0	54,412	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27,599	27,599	0	27,599	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,238	27,238	0	27,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,912	239,381	367,293	0	367,293	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	208	208	0	208	90.00
91.00	09100	EMERGENCY	373,909	98,842	472,751	0	472,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,928,631	3,216,827	6,145,458	0	6,145,458	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	76,581	104,492	181,073	0	181,073	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	3,005,212	3,321,319	6,326,531	0	6,326,531	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 5:00 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	244,196	509,329		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	114,169		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	868,457	868,457		4.00
5.01	00540	NONPATIENT TELEPHONES	9,590	22,596		5.01
5.02	00550	DATA PROCESSING	518,846	758,412		5.02
5.03	00561	PURCHASING RECEIVING AND STORES	31,036	33,556		5.03
5.04	00570	ADMITTING	0	172,433		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	139,198	270,612		5.05
5.06	00590	OTHER ADMIN AND GENERAL	216,634	743,788		5.06
7.00	00700	OPERATION OF PLANT	40,797	350,698		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	976		8.00
9.00	00900	HOUSEKEEPING	15,838	117,817		9.00
10.00	01000	DIETARY	2,043	47,720		10.00
11.00	01100	CAFETERIA	-52,631	82,558		11.00
13.00	01300	NURSING ADMINISTRATION	16,512	225,228		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,096	93,601		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-87,370	502,955		30.00
31.00	03100	INTENSIVE CARE UNIT	0	255,387		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,123	367,245		50.00
51.00	05100	RECOVERY ROOM	83	25,171		51.00
51.01	05101	O/P TREATMENT ROOM	0	62,649		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-214,892	461,364		54.00
56.00	05600	RADIOISOTOPE	0	37,213		56.00
60.00	06000	LABORATORY	0	333,211		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	25,975		62.00
65.00	06500	RESPIRATORY THERAPY	0	144,590		65.00
66.00	06600	PHYSICAL THERAPY	-140,750	171,575		66.00
67.00	06700	OCCUPATIONAL THERAPY	51,256	53,420		67.00
68.00	06800	SPEECH PATHOLOGY	-678	7,636		68.00
69.00	06900	ELECTROCARDIOLOGY	-7	54,405		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27,599		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,238		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,041	377,334		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	208		90.00
91.00	09100	EMERGENCY	0	472,751		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,674,418	7,819,876		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PHYSICIAN PRACTICES	0	181,073		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		194.01
194.02	07952	VPCHC	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	1,674,418	8,000,949		200.00

RECLASSIFICATIONS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 5:00 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	78,983	56,206		1.00
	0		78,983	56,206		
500.00	Grand Total: Increases		78,983	56,206		500.00

RECLASSIFICATIONS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 5:00 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	78,983	56,206	0		1.00
	0		78,983	56,206			
500.00	Grand Total: Decreases		78,983	56,206			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2015 5:00 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	339,822	0	0	0	0	1.00
2.00	Land Improvements	269,938	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,399,638	7,363	0	7,363	0	3.00
4.00	Building Improvements	1,645,471	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,703,508	16,539	0	16,539	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,358,377	23,902	0	23,902	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,358,377	23,902	0	23,902	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	339,822	0	1.00
2.00	Land Improvements	269,938	0	2.00
3.00	Buildings and Fixtures	11,407,001	0	3.00
4.00	Building Improvements	1,645,471	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	5,720,047	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,382,279	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	19,382,279	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2015 5:00 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	265,133	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	114,169	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	379,302	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	265,133		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	114,169		2.00
3.00	Total (sum of lines 1-2)	0	379,302		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2015 5:00 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	13,662,232	0	13,662,232	0.704883	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	5,720,047	0	5,720,047	0.295117	0	2.00
3.00	Total (sum of lines 1-2)	19,382,279	0	19,382,279	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	509,329	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	114,169	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	623,498	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	509,329	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	114,169	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	623,498	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 5:00 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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	-325,400			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	2,337,245			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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 - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 5:00 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	CHART FEE REVENUE	B	-1,100	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
35.00	CAFETERIA REVENUE	B	-58,107	CAFETERIA	11.00	0	35.00
36.00	CAFETERIA REVENUE	B	-1,659	CAFETERIA	11.00	0	36.00
39.00	ADVERTISING	A	-424	OTHER ADMIN AND GENERAL	5.06	0	39.00
41.00	MISC REVENUE	B	-2,707	OTHER ADMIN AND GENERAL	5.06	0	41.00
42.00	VPCHC	B	-1,918	HOUSEKEEPING	9.00	0	42.00
43.00	RENTAL REVENUE	B	-45,877	OPERATION OF PLANT	7.00	0	43.00
44.00	HAF	A	-174,585	OTHER ADMIN AND GENERAL	5.06	0	44.00
45.00	PHYSICIAN RECRUITMENT	A	-16,667	OTHER ADMIN AND GENERAL	5.06	0	45.00
47.00	EHR DEPRECIATION	A	-34,383	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	47.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,674,418				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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2015 5:00 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	278,579	0	1.00
2.00	9.00	HOUSEKEEPING	HOME OFFICE	17,756	0	2.00
3.00	5.01	NONPATIENT TELEPHONES	HOME OFFICE	9,590	0	3.00
4.00	50.00	OPERATING ROOM	HOME OFFICE	2,123	0	4.00
4.01	51.00	RECOVERY ROOM	HOME OFFICE	83	0	4.01
4.02	54.00	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	20,840	0	4.02
4.03	66.00	PHYSICAL THERAPY	HOME OFFICE	3,792	0	4.03
4.04	67.00	OCCUPATIONAL THERAPY	HOME OFFICE	1,325	0	4.04
4.05	68.00	SPEECH PATHOLOGY	HOME OFFICE	170	0	4.05
4.06	69.00	ELECTROCARDIOLOGY	HOME OFFICE	2,291	0	4.06
4.07	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	10,041	0	4.07
4.08	7.00	OPERATION OF PLANT	HOME OFFICE	86,674	0	4.08
4.09	10.00	DIETARY	HOME OFFICE	2,043	0	4.09
4.10	11.00	CAFETERIA	HOME OFFICE	7,135	0	4.10
4.11	5.03	PURCHASING RECEIVING AND STO	HOME OFFICE	31,036	0	4.11
4.12	5.02	DATA PROCESSING	HOME OFFICE	518,846	0	4.12
4.13	13.00	NURSING ADMINISTRATION	HOME OFFICE	16,512	0	4.13
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	868,457	0	4.14
4.15	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	5,196	0	4.15
4.16	5.05	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	139,198	0	4.16
4.17	5.06	OTHER ADMIN AND GENERAL	HOME OFFICE	411,017	0	4.17
4.18	66.00	PHYSICAL THERAPY	THERAPY	142,957	287,499	4.18
4.19	67.00	OCCUPATIONAL THERAPY	THERAPY	49,931	0	4.19
4.20	68.00	SPEECH PATHOLOGY	THERAPY	6,394	7,242	4.20
5.00	0		0	2,631,986	294,741	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	G		0.00	TH MEDICAL LAB	100.00	6.00
7.00	G		0.00	UNION HOSPITAL	100.00	7.00
8.00	G		0.00	UNION THERAPY	51.00	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:	OTHER				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: 151326	Period: From 09/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/27/2015 5:00 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	278,579	9		1.00
2.00	17,756	0		2.00
3.00	9,590	0		3.00
4.00	2,123	0		4.00
4.01	83	0		4.01
4.02	20,840	0		4.02
4.03	3,792	0		4.03
4.04	1,325	0		4.04
4.05	170	0		4.05
4.06	2,291	0		4.06
4.07	10,041	0		4.07
4.08	86,674	0		4.08
4.09	2,043	0		4.09
4.10	7,135	0		4.10
4.11	31,036	0		4.11
4.12	518,846	0		4.12
4.13	16,512	0		4.13
4.14	868,457	0		4.14
4.15	5,196	0		4.15
4.16	139,198	0		4.16
4.17	411,017	0		4.17
4.18	-144,542	0		4.18
4.19	49,931	0		4.19
4.20	-848	0		4.20
5.00	2,337,245			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	LAB		6.00
7.00	HOME OFFICE		7.00
8.00	THERAPY		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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2015 5:00 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	87,370	87,370	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	235,732	235,732	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	2,298	2,298	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		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			325,400	325,400	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		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	30.00	ADULTS & PEDIATRICS	0	0	0	87,370		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	235,732		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,298		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		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	325,400		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	509,329	509,329				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	114,169		114,169			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	868,457	0	0	868,457		4.00
5.01	00540	NONPATIENT TELEPHONES	22,596	540	8,038	0	31,174	5.01
5.02	00550	DATA PROCESSING	758,412	1,054	22,106	0	358	5.02
5.03	00561	PURCHASING RECEIVING AND STORES	33,556	4,105	106	0	239	5.03
5.04	00570	ADMITTING	172,433	2,616	226	44,029	717	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	270,612	1,547	0	2,043	478	5.05
5.06	00590	OTHER ADMIN AND GENERAL	743,788	7,650	4,376	61,151	1,792	5.06
7.00	00700	OPERATION OF PLANT	350,698	112,271	4,082	34,782	2,508	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	976	2,149	157	0	0	8.00
9.00	00900	HOUSEKEEPING	117,817	2,034	848	21,690	119	9.00
10.00	01000	DIETARY	47,720	5,792	1,191	7,712	239	10.00
11.00	01100	CAFETERIA	82,558	17,375	3,573	22,825	597	11.00
13.00	01300	NURSING ADMINISTRATION	225,228	7,172	686	51,562	478	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93,601	4,541	86	16,869	1,075	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	502,955	72,594	5,470	146,593	8,719	30.00
31.00	03100	INTENSIVE CARE UNIT	255,387	2,128	20,119	65,621	717	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	367,245	15,491	13,187	29,288	836	50.00
51.00	05100	RECOVERY ROOM	25,171	1,562	573	6,743	239	51.00
51.01	05101	O/P TREATMENT ROOM	62,649	8,345	1,207	14,956	1,314	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	461,364	30,334	9,691	134,076	1,672	54.00
56.00	05600	RADIOISOTOPE	37,213	1,365	0	0	119	56.00
60.00	06000	LABORATORY	333,211	8,880	0	0	597	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	25,975	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	144,590	3,135	3,281	31,317	836	65.00
66.00	06600	PHYSICAL THERAPY	171,575	17,536	910	0	1,314	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,420	14,749	92	0	956	67.00
68.00	06800	SPEECH PATHOLOGY	7,636	1,993	0	0	239	68.00
69.00	06900	ELECTROCARDIOLOGY	54,405	2,174	2,524	10,050	597	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,599	5,273	0	0	119	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,238	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	377,334	5,262	328	36,965	717	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	208	415	0	0	0	90.00
91.00	09100	EMERGENCY	472,751	43,646	10,906	108,054	3,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,819,876	403,728	113,763	846,326	31,174	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	181,073	17,770	406	22,131	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	47,019	0	0	0	194.01
194.02	07952	VPCHC	0	40,812	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,000,949	509,329	114,169	868,457	31,174	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	781,930					5.02
5.03	00561	PURCHASING RECEIVING AND STORES	0	38,006				5.03
5.04	00570	ADMITTING	37,235	55	257,311			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	12,412	0	0	287,092		5.05
5.06	00590	OTHER ADMIN AND GENERAL	80,675	7	0	0	899,439	5.06
7.00	00700	OPERATION OF PLANT	161,349	9	0	0	665,699	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	272	0	0	3,554	8.00
9.00	00900	HOUSEKEEPING	6,206	2,943	0	0	151,657	9.00
10.00	01000	DIETARY	6,206	4	0	0	68,864	10.00
11.00	01100	CAFETERIA	12,412	12	0	0	139,352	11.00
13.00	01300	NURSING ADMINISTRATION	24,823	0	0	0	309,949	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49,646	0	0	0	165,818	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	68,264	6,300	58,808	20,038	889,741	30.00
31.00	03100	INTENSIVE CARE UNIT	6,206	2,229	20,808	4,838	378,053	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,823	12,991	37,927	23,958	525,746	50.00
51.00	05100	RECOVERY ROOM	0	0	822	933	36,043	51.00
51.01	05101	O/P TREATMENT ROOM	6,206	1,380	309	3,820	100,186	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,852	2,400	24,689	78,588	798,666	54.00
56.00	05600	RADIOISOTOPE	0	56	1,225	2,869	42,847	56.00
60.00	06000	LABORATORY	6,206	0	25,459	32,219	406,572	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	702	252	26,929	62.00
65.00	06500	RESPIRATORY THERAPY	12,412	847	8,671	3,046	208,135	65.00
66.00	06600	PHYSICAL THERAPY	24,823	82	4,033	1,053	221,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4	0	8,625	77,846	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	9,868	68.00
69.00	06900	ELECTROCARDIOLOGY	0	36	9,500	9,636	88,922	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,144	311	34,446	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	27,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,617	66	49,251	26,836	515,376	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	623	90.00
91.00	09100	EMERGENCY	68,264	8,123	13,963	67,979	797,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	682,637	37,816	257,311	285,001	7,590,164	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	99,293	190	0	2,091	322,954	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	47,019	194.01
194.02	07952	VPCHC	0	0	0	0	40,812	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	781,930	38,006	257,311	287,092	8,000,949	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00561	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN AND GENERAL	899,439					5.06
7.00	00700	OPERATION OF PLANT	84,314	750,013				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	450	5,308	9,312			8.00
9.00	00900	HOUSEKEEPING	19,208	5,026	0	175,891		9.00
10.00	01000	DIETARY	8,722	14,308	0	3,402	95,296	10.00
11.00	01100	CAFETERIA	17,650	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	39,257	17,719	0	4,213	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,002	11,219	0	2,668	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	112,687	179,342	3,388	42,648	73,963	30.00
31.00	03100	INTENSIVE CARE UNIT	47,882	5,257	484	1,250	15,047	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	66,588	38,271	481	9,101	0	50.00
51.00	05100	RECOVERY ROOM	4,565	3,859	0	918	0	51.00
51.01	05101	O/P TREATMENT ROOM	12,689	20,616	0	4,902	6,286	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	101,155	74,940	758	17,820	0	54.00
56.00	05600	RADIOISOTOPE	5,427	3,372	0	802	0	56.00
60.00	06000	LABORATORY	51,494	21,937	0	5,216	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,411	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	26,361	7,744	0	1,841	0	65.00
66.00	06600	PHYSICAL THERAPY	28,032	43,323	873	10,302	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,860	36,438	0	8,665	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,250	4,923	0	1,171	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,262	5,372	108	1,277	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,363	13,026	0	3,098	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,450	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,275	13,001	0	3,091	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	79	1,026	0	244	0	90.00
91.00	09100	EMERGENCY	100,978	107,826	3,220	25,640	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	847,411	633,853	9,312	148,269	95,296	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	40,904	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	5,955	116,160	0	27,622	0	194.01
194.02	07952	VPCHC	5,169	0	0	0	0	194.02
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)	899,439	750,013	9,312	175,891	95,296	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00561	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN AND GENERAL						5.06
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	157,002					11.00
13.00	01300	NURSING ADMINISTRATION	10,747	381,885				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,342	0	208,049			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,040	190,687	14,628	1,549,124	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,763	71,496	3,532	538,764	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,824	35,520	17,489	701,020	0	50.00
51.00	05100	RECOVERY ROOM	1,678	7,590	681	55,334	0	51.00
51.01	05101	O/P TREATMENT ROOM	3,920	0	2,788	151,387	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,484	0	57,373	1,070,196	0	54.00
56.00	05600	RADIOISOTOPE	0	0	2,094	54,542	0	56.00
60.00	06000	LABORATORY	0	0	23,519	508,738	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	184	30,524	0	62.00
65.00	06500	RESPIRATORY THERAPY	8,189	37,136	2,223	291,629	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	768	304,624	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	6,296	139,105	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	17,212	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,143	2,656	7,034	118,774	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	227	55,160	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	30,688	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,106	36,800	19,590	661,239	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,972	0	90.00
91.00	09100	EMERGENCY	27,706	0	49,623	1,112,262	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	154,942	381,885	208,049	7,392,294	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	2,060	0	0	365,918	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	196,756	0	194.01
194.02	07952	VPCHC	0	0	0	45,981	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	157,002	381,885	208,049	8,000,949	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00561	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00590	OTHER ADMIN AND GENERAL			5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,549,124		30.00
31.00	03100	INTENSIVE CARE UNIT	538,764		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	701,020		50.00
51.00	05100	RECOVERY ROOM	55,334		51.00
51.01	05101	O/P TREATMENT ROOM	151,387		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,070,196		54.00
56.00	05600	RADIOISOTOPE	54,542		56.00
60.00	06000	LABORATORY	508,738		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,524		62.00
65.00	06500	RESPIRATORY THERAPY	291,629		65.00
66.00	06600	PHYSICAL THERAPY	304,624		66.00
67.00	06700	OCCUPATIONAL THERAPY	139,105		67.00
68.00	06800	SPEECH PATHOLOGY	17,212		68.00
69.00	06900	ELECTROCARDIOLOGY	118,774		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,160		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,688		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	661,239		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1,972		90.00
91.00	09100	EMERGENCY	1,112,262		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,392,294		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	365,918		194.00
194.01	07951	MEDICAL OFFICE BUILDING	196,756		194.01
194.02	07952	VPCHC	45,981		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	8,000,949		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	540	8,038	8,578	0	5.01
5.02	00550	DATA PROCESSING	0	1,054	22,106	23,160	0	5.02
5.03	00561	PURCHASING RECEIVING AND STORES	0	4,105	106	4,211	0	5.03
5.04	00570	ADMITTING	0	2,616	226	2,842	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,547	0	1,547	0	5.05
5.06	00590	OTHER ADMIN AND GENERAL	0	7,650	4,376	12,026	0	5.06
7.00	00700	OPERATION OF PLANT	0	112,271	4,082	116,353	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,149	157	2,306	0	8.00
9.00	00900	HOUSEKEEPING	0	2,034	848	2,882	0	9.00
10.00	01000	DIETARY	0	5,792	1,191	6,983	0	10.00
11.00	01100	CAFETERIA	0	17,375	3,573	20,948	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,172	686	7,858	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,541	86	4,627	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	72,594	5,470	78,064	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,128	20,119	22,247	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,491	13,187	28,678	0	50.00
51.00	05100	RECOVERY ROOM	0	1,562	573	2,135	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	8,345	1,207	9,552	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,334	9,691	40,025	0	54.00
56.00	05600	RADIOISOTOPE	0	1,365	0	1,365	0	56.00
60.00	06000	LABORATORY	0	8,880	0	8,880	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,135	3,281	6,416	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,536	910	18,446	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,749	92	14,841	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,993	0	1,993	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,174	2,524	4,698	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,273	0	5,273	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,262	328	5,590	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	415	0	415	0	90.00
91.00	09100	EMERGENCY	0	43,646	10,906	54,552	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	403,728	113,763	517,491	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	17,770	406	18,176	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	47,019	0	47,019	0	194.01
194.02	07952	VPCHC	0	40,812	0	40,812	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	509,329	114,169	623,498	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	8,578					5.01
5.02	00550	DATA PROCESSING	99	23,259				5.02
5.03	00561	PURCHASING RECEIVING AND STORES	66	0	4,277			5.03
5.04	00570	ADMITTING	197	1,108	6	4,153		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	131	369	0	0	2,047	5.05
5.06	00590	OTHER ADMIN AND GENERAL	493	2,400	1	0	0	5.06
7.00	00700	OPERATION OF PLANT	690	4,797	1	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	31	0	0	8.00
9.00	00900	HOUSEKEEPING	33	185	331	0	0	9.00
10.00	01000	DIETARY	66	185	0	0	0	10.00
11.00	01100	CAFETERIA	164	369	1	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	131	738	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	296	1,477	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,399	2,031	709	950	142	30.00
31.00	03100	INTENSIVE CARE UNIT	197	185	251	336	34	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230	738	1,465	612	170	50.00
51.00	05100	RECOVERY ROOM	66	0	0	13	7	51.00
51.01	05101	O/P TREATMENT ROOM	362	185	155	5	27	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	460	1,661	270	399	569	54.00
56.00	05600	RADIOISOTOPE	33	0	6	20	20	56.00
60.00	06000	LABORATORY	164	185	0	411	229	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	11	2	62.00
65.00	06500	RESPIRATORY THERAPY	230	369	95	140	22	65.00
66.00	06600	PHYSICAL THERAPY	362	738	9	65	7	66.00
67.00	06700	OCCUPATIONAL THERAPY	263	0	0	0	61	67.00
68.00	06800	SPEECH PATHOLOGY	66	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	164	0	4	153	68	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33	0	0	18	2	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	197	554	7	795	190	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	986	2,031	914	225	482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,578	20,305	4,256	4,153	2,032	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	2,954	21	0	15	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	8,578	23,259	4,277	4,153	2,047	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00561	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN AND GENERAL	14,920					5.06
7.00	00700	OPERATION OF PLANT	1,399	123,240				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7	872	3,216			8.00
9.00	00900	HOUSEKEEPING	319	826	0	4,576		9.00
10.00	01000	DIETARY	145	2,351	0	89	9,819	10.00
11.00	01100	CAFETERIA	293	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	651	2,912	0	110	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	348	1,843	0	69	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,868	29,468	1,171	1,108	7,621	30.00
31.00	03100	INTENSIVE CARE UNIT	794	864	167	33	1,550	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,105	6,289	166	237	0	50.00
51.00	05100	RECOVERY ROOM	76	634	0	24	0	51.00
51.01	05101	O/P TREATMENT ROOM	210	3,388	0	128	648	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,678	12,314	262	464	0	54.00
56.00	05600	RADIOISOTOPE	90	554	0	21	0	56.00
60.00	06000	LABORATORY	854	3,605	0	136	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	57	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	437	1,272	0	48	0	65.00
66.00	06600	PHYSICAL THERAPY	465	7,119	301	268	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	164	5,987	0	225	0	67.00
68.00	06800	SPEECH PATHOLOGY	21	809	0	30	0	68.00
69.00	06900	ELECTROCARDIOLOGY	187	883	37	33	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	72	2,140	0	81	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,083	2,136	0	80	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1	169	0	6	0	90.00
91.00	09100	EMERGENCY	1,675	17,718	1,112	667	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,056	104,153	3,216	3,857	9,819	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	679	0	0	0	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	99	19,087	0	719	0	194.01
194.02	07952	VPCHC	86	0	0	0	0	194.02
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)	14,920	123,240	3,216	4,576	9,819	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00561	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN AND GENERAL						5.06
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	21,775					11.00
13.00	01300	NURSING ADMINISTRATION	1,491	13,891				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,018	0	9,678			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,830	6,935	681	138,977	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,186	2,601	164	31,609	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,085	1,292	814	42,881	0	50.00
51.00	05100	RECOVERY ROOM	233	276	32	3,496	0	51.00
51.01	05101	O/P TREATMENT ROOM	544	0	130	15,334	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,702	0	2,660	63,464	0	54.00
56.00	05600	RADIOISOTOPE	0	0	98	2,207	0	56.00
60.00	06000	LABORATORY	0	0	1,095	15,559	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	9	79	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,136	1,351	104	11,620	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	36	27,816	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	293	21,834	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,919	0	68.00
69.00	06900	ELECTROCARDIOLOGY	297	97	328	6,949	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	11	7,630	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	57	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,124	1,339	912	14,007	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	591	0	90.00
91.00	09100	EMERGENCY	3,843	0	2,311	86,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,489	13,891	9,678	493,545	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	286	0	0	22,131	0	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	66,924	0	194.01
194.02	07952	VPCHC	0	0	0	40,898	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,775	13,891	9,678	623,498	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00561	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00590	OTHER ADMIN AND GENERAL			5.06
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	138,977		30.00
31.00	03100	INTENSIVE CARE UNIT	31,609		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	42,881		50.00
51.00	05100	RECOVERY ROOM	3,496		51.00
51.01	05101	O/P TREATMENT ROOM	15,334		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,464		54.00
56.00	05600	RADIOISOTOPE	2,207		56.00
60.00	06000	LABORATORY	15,559		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79		62.00
65.00	06500	RESPIRATORY THERAPY	11,620		65.00
66.00	06600	PHYSICAL THERAPY	27,816		66.00
67.00	06700	OCCUPATIONAL THERAPY	21,834		67.00
68.00	06800	SPEECH PATHOLOGY	2,919		68.00
69.00	06900	ELECTROCARDIOLOGY	6,949		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,630		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,007		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	591		90.00
91.00	09100	EMERGENCY	86,516		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	493,545		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	PHYSICIAN PRACTICES	22,131		194.00
194.01	07951	MEDICAL OFFICE BUILDING	66,924		194.01
194.02	07952	VPCHC	40,898		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	623,498		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQ FT)	NEW MVBLE EQUIP (EQUIP DEPRN)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (PHONES)	DATA PROCESSING (DEVICES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	98,142					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		113,545				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,005,212			4.00
5.01	00540	NONPATIENT TELEPHONES	104	7,994	0	261		5.01
5.02	00550	DATA PROCESSING	203	21,988	0	3	126	5.02
5.03	00561	PURCHASING RECEIVING AND STORES	791	105	0	2	0	5.03
5.04	00570	ADMITTING	504	225	152,359	6	6	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	298	0	7,070	4	2	5.05
5.06	00590	OTHER ADMIN AND GENERAL	1,474	4,352	211,606	15	13	5.06
7.00	00700	OPERATION OF PLANT	21,634	4,060	120,360	21	26	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	156	0	0	0	8.00
9.00	00900	HOUSEKEEPING	392	843	75,057	1	1	9.00
10.00	01000	DIETARY	1,116	1,184	26,687	2	1	10.00
11.00	01100	CAFETERIA	3,348	3,553	78,983	5	2	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	682	178,426	4	4	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	86	58,374	9	8	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	5,440	507,269	73	11	30.00
31.00	03100	INTENSIVE CARE UNIT	410	20,009	227,076	6	1	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,985	13,115	101,348	7	4	50.00
51.00	05100	RECOVERY ROOM	301	570	23,335	2	0	51.00
51.01	05101	O/P TREATMENT ROOM	1,608	1,200	51,755	11	1	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,845	9,638	463,957	14	9	54.00
56.00	05600	RADIOISOTOPE	263	0	0	1	0	56.00
60.00	06000	LABORATORY	1,711	0	0	5	1	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	604	3,263	108,370	7	2	65.00
66.00	06600	PHYSICAL THERAPY	3,379	905	0	11	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	91	0	8	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	0	2	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	2,510	34,778	5	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	0	1	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,014	326	127,912	6	3	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	80	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,410	10,846	373,909	30	11	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,794	113,141	2,928,631	261	110	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	3,424	404	76,581	0	16	194.00
194.01	07951	MEDICAL OFFICE BUILDING	9,060	0	0	0	0	194.01
194.02	07952	VPCHC	7,864	0	0	0	0	194.02
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)	509,329	114,169	868,457	31,174	781,930	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.189715	1.005496	0.288984	119.440613	6,205.793651	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	8,578	23,259	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	32.865900	184.595238	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (REQUISITIO)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (TOTAL REVENUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00561	PURCHASING RECEIVING AND STORES	131,290					5.03
5.04	00570	ADMITTING	190	5,174,676				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	24,830,521			5.05
5.06	00590	OTHER ADMIN AND GENERAL	23	0	0	-899,439	7,101,510	5.06
7.00	00700	OPERATION OF PLANT	32	0	0	0	665,699	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	941	0	0	0	3,554	8.00
9.00	00900	HOUSEKEEPING	10,167	0	0	0	151,657	9.00
10.00	01000	DIETARY	14	0	0	0	68,864	10.00
11.00	01100	CAFETERIA	41	0	0	0	139,352	11.00
13.00	01300	NURSING ADMINISTRATION	1	0	0	0	309,949	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	165,818	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,763	1,182,660	1,733,126	0	889,741	30.00
31.00	03100	INTENSIVE CARE UNIT	7,700	418,469	418,469	0	378,053	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,874	762,731	2,072,123	0	525,746	50.00
51.00	05100	RECOVERY ROOM	0	16,533	80,703	0	36,043	51.00
51.01	05101	O/P TREATMENT ROOM	4,767	6,205	330,352	0	100,186	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,290	496,517	6,796,960	0	798,666	54.00
56.00	05600	RADIOISOTOPE	192	24,633	248,143	0	42,847	56.00
60.00	06000	LABORATORY	0	511,995	2,786,640	0	406,572	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	14,117	21,817	0	26,929	62.00
65.00	06500	RESPIRATORY THERAPY	2,927	174,389	263,406	0	208,135	65.00
66.00	06600	PHYSICAL THERAPY	282	81,108	91,052	0	221,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	15	0	745,947	0	77,846	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	9,868	68.00
69.00	06900	ELECTROCARDIOLOGY	123	191,050	833,420	0	88,922	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,997	26,895	0	34,446	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	27,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	229	990,458	2,321,093	0	515,376	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	623	90.00
91.00	09100	EMERGENCY	28,062	280,814	5,879,512	0	797,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	130,633	5,174,676	24,649,658	-899,439	6,690,725	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	657	0	180,863	0	322,954	194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0	0	0	47,019	194.01
194.02	07952	VPCHC	0	0	0	0	40,812	194.02
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)	38,006	257,311	287,092		899,439	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.289481	0.049725	0.011562		0.126655	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,277	4,153	2,047		14,920	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.032577	0.000803	0.000082		0.002101	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	OPERATION OF PLANT (SQ FT)	LAUNDRY & LINEN SERVICE (LINEN)	HOUSEKEEPING (NUMBER HOUSED)	DIETARY (DIETARY)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00561	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	58,498					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	25,537				8.00
9.00	00900	HOUSEKEEPING	392	0	57,692			9.00
10.00	01000	DIETARY	1,116	0	1,116	2,926		10.00
11.00	01100	CAFETERIA	0	0	0	0	9,452	11.00
13.00	01300	NURSING ADMINISTRATION	1,382	0	1,382	0	647	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	875	0	875	0	442	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,988	9,292	13,988	2,271	2,531	30.00
31.00	03100	INTENSIVE CARE UNIT	410	1,327	410	462	949	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,985	1,319	2,985	0	471	50.00
51.00	05100	RECOVERY ROOM	301	0	301	0	101	51.00
51.01	05101	O/P TREATMENT ROOM	1,608	0	1,608	193	236	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,845	2,078	5,845	0	1,173	54.00
56.00	05600	RADIOISOTOPE	263	0	263	0	0	56.00
60.00	06000	LABORATORY	1,711	0	1,711	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	604	0	604	0	493	65.00
66.00	06600	PHYSICAL THERAPY	3,379	2,393	3,379	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,842	0	2,842	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	384	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	419	297	419	0	129	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,016	0	1,016	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,014	0	1,014	0	488	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	80	0	80	0	0	90.00
91.00	09100	EMERGENCY	8,410	8,831	8,410	0	1,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,438	25,537	48,632	2,926	9,328	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	PHYSICIAN PRACTICES	0	0	0	0	124	194.00
194.01	07951	MEDICAL OFFICE BUILDING	9,060	0	9,060	0	0	194.01
194.02	07952	VPCHC	0	0	0	0	0	194.02
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)	750,013	9,312	175,891	95,296	157,002	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.821173	0.364647	3.048794	32.568694	16.610453	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	123,240	3,216	4,576	9,819	21,775	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.106739	0.125935	0.079318	3.355776	2.303745	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 5:00 pm

		Cost Center Description	NURSING ADMINISTRATION (TIME SPENT)	MEDICAL RECORDS & LIBRARY (ASSIGNED TIME)		
			13.00	16.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00561	PURCHASING RECEIVING AND STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00590	OTHER ADMIN AND GENERAL				5.06
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	35,221			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,649,658		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	17,587	1,733,126		30.00
31.00	03100	INTENSIVE CARE UNIT	6,594	418,469		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,276	2,072,123		50.00
51.00	05100	RECOVERY ROOM	700	80,703		51.00
51.01	05101	O/P TREATMENT ROOM	0	330,352		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,796,960		54.00
56.00	05600	RADIOISOTOPE	0	248,143		56.00
60.00	06000	LABORATORY	0	2,786,640		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	21,817		62.00
65.00	06500	RESPIRATORY THERAPY	3,425	263,406		65.00
66.00	06600	PHYSICAL THERAPY	0	91,052		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	745,947		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	245	833,420		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,895		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,394	2,321,093		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	5,879,512		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	35,221	24,649,658		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	PHYSICIAN PRACTICES	0	0		194.00
194.01	07951	MEDICAL OFFICE BUILDING	0	0		194.01
194.02	07952	VPCHC	0	0		194.02
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)	381,885	208,049		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.842537	0.008440		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,891	9,678		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.394395	0.000393		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,549,124		1,549,124	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	538,764		538,764	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	701,020		701,020	0	0	50.00
51.00	05100	RECOVERY ROOM	55,334		55,334	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	151,387		151,387	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,070,196		1,070,196	0	0	54.00
56.00	05600	RADIOISOTOPE	54,542		54,542	0	0	56.00
60.00	06000	LABORATORY	508,738		508,738	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,524		30,524	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	291,629	0	291,629	0	0	65.00
66.00	06600	PHYSICAL THERAPY	304,624	0	304,624	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,105	0	139,105	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,212	0	17,212	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	118,774		118,774	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,160		55,160	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,688		30,688	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	661,239		661,239	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,972		1,972	0	0	90.00
91.00	09100	EMERGENCY	1,112,262		1,112,262	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	418,003		418,003		0	92.00
200.00		Subtotal (see instructions)	7,810,297	0	7,810,297	0	0	200.00
201.00		Less Observation Beds	418,003		418,003		0	201.00
202.00		Total (see instructions)	7,392,294	0	7,392,294	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,157,183		1,157,183			30.00
31.00	03100	INTENSIVE CARE UNIT	418,469		418,469			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	760,781	1,292,698	2,053,479	0.341382	0.000000	50.00
51.00	05100	RECOVERY ROOM	16,533	64,170	80,703	0.685650	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	3,789	316,206	319,995	0.473092	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,033	5,804,484	6,278,517	0.170454	0.000000	54.00
56.00	05600	RADIOISOTOPE	24,633	223,510	248,143	0.219801	0.000000	56.00
60.00	06000	LABORATORY	511,995	2,274,645	2,786,640	0.182563	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,117	7,700	21,817	1.399092	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	174,389	89,017	263,406	1.107146	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	54,307	546,122	600,429	0.507344	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,543	186,170	209,713	0.663311	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,258	23,599	26,857	0.640876	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	191,050	631,768	822,818	0.144350	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,997	3,898	26,895	2.050939	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,950	16,694	18,644	1.645999	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	990,458	1,330,635	2,321,093	0.284883	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	280,814	5,598,698	5,879,512	0.189176	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	21,443	497,941	519,384	0.804805	0.000000	92.00
200.00		Subtotal (see instructions)	5,145,742	18,907,955	24,053,697			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,145,742	18,907,955	24,053,697			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	O/P TREATMENT ROOM	0.000000		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
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 PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:00 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	1,549,124		1,549,124	0	1,549,124	30.00
31.00	03100	INTENSIVE CARE UNIT	538,764		538,764	0	538,764	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	701,020		701,020	0	701,020	50.00
51.00	05100	RECOVERY ROOM	55,334		55,334	0	55,334	51.00
51.01	05101	O/P TREATMENT ROOM	151,387		151,387	0	151,387	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,070,196		1,070,196	0	1,070,196	54.00
56.00	05600	RADIOISOTOPE	54,542		54,542	0	54,542	56.00
60.00	06000	LABORATORY	508,738		508,738	0	508,738	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	30,524		30,524	0	30,524	62.00
65.00	06500	RESPIRATORY THERAPY	291,629	0	291,629	0	291,629	65.00
66.00	06600	PHYSICAL THERAPY	304,624	0	304,624	0	304,624	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,105	0	139,105	0	139,105	67.00
68.00	06800	SPEECH PATHOLOGY	17,212	0	17,212	0	17,212	68.00
69.00	06900	ELECTROCARDIOLOGY	118,774		118,774	0	118,774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,160		55,160	0	55,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,688		30,688	0	30,688	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	661,239		661,239	0	661,239	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,972		1,972	0	1,972	90.00
91.00	09100	EMERGENCY	1,112,262		1,112,262	0	1,112,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	418,003		418,003		418,003	92.00
200.00		Subtotal (see instructions)	7,810,297	0	7,810,297	0	7,810,297	200.00
201.00		Less Observation Beds	418,003		418,003		418,003	201.00
202.00		Total (see instructions)	7,392,294	0	7,392,294	0	7,392,294	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:00 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	1,157,183		1,157,183			30.00
31.00	03100	INTENSIVE CARE UNIT	418,469		418,469			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	760,781	1,292,698	2,053,479	0.341382	0.000000	50.00
51.00	05100	RECOVERY ROOM	16,533	64,170	80,703	0.685650	0.000000	51.00
51.01	05101	O/P TREATMENT ROOM	3,789	316,206	319,995	0.473092	0.000000	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	474,033	5,804,484	6,278,517	0.170454	0.000000	54.00
56.00	05600	RADIOISOTOPE	24,633	223,510	248,143	0.219801	0.000000	56.00
60.00	06000	LABORATORY	511,995	2,274,645	2,786,640	0.182563	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,117	7,700	21,817	1.399092	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	174,389	89,017	263,406	1.107146	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	54,307	546,122	600,429	0.507344	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,543	186,170	209,713	0.663311	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,258	23,599	26,857	0.640876	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	191,050	631,768	822,818	0.144350	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,997	3,898	26,895	2.050939	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,950	16,694	18,644	1.645999	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	990,458	1,330,635	2,321,093	0.284883	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	280,814	5,598,698	5,879,512	0.189176	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	21,443	497,941	519,384	0.804805	0.000000	92.00
200.00		Subtotal (see instructions)	5,145,742	18,907,955	24,053,697			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,145,742	18,907,955	24,053,697			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 5:00 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
51.01	05101	O/P TREATMENT ROOM	0.000000		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
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 PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,881	2,053,479	0.020882	264,213	5,517	50.00
51.00	05100	RECOVERY ROOM	3,496	80,703	0.043319	5,718	248	51.00
51.01	05101	O/P TREATMENT ROOM	15,334	319,995	0.047919	2,170	104	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	63,464	6,278,517	0.010108	136,349	1,378	54.00
56.00	05600	RADIOISOTOPE	2,207	248,143	0.008894	11,843	105	56.00
60.00	06000	LABORATORY	15,559	2,786,640	0.005583	214,418	1,197	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79	21,817	0.003621	9,709	35	62.00
65.00	06500	RESPIRATORY THERAPY	11,620	263,406	0.044114	103,540	4,568	65.00
66.00	06600	PHYSICAL THERAPY	27,816	600,429	0.046327	24,837	1,151	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,834	209,713	0.104114	11,698	1,218	67.00
68.00	06800	SPEECH PATHOLOGY	2,919	26,857	0.108687	2,988	325	68.00
69.00	06900	ELECTROCARDIOLOGY	6,949	822,818	0.008445	132,809	1,122	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,630	26,895	0.283696	8,608	2,442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57	18,644	0.003057	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,007	2,321,093	0.006035	468,271	2,826	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	591	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	86,516	5,879,512	0.014715	857	13	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	41,921	519,384	0.080713	1,570	127	92.00
200.00		Total (lines 50-199)	364,880	22,478,045		1,399,598	22,376	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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 PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,053,479	0.000000	0.000000	264,213	50.00
51.00	05100	RECOVERY ROOM	0	80,703	0.000000	0.000000	5,718	51.00
51.01	05101	O/P TREATMENT ROOM	0	319,995	0.000000	0.000000	2,170	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,278,517	0.000000	0.000000	136,349	54.00
56.00	05600	RADIOISOTOPE	0	248,143	0.000000	0.000000	11,843	56.00
60.00	06000	LABORATORY	0	2,786,640	0.000000	0.000000	214,418	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	21,817	0.000000	0.000000	9,709	62.00
65.00	06500	RESPIRATORY THERAPY	0	263,406	0.000000	0.000000	103,540	65.00
66.00	06600	PHYSICAL THERAPY	0	600,429	0.000000	0.000000	24,837	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	209,713	0.000000	0.000000	11,698	67.00
68.00	06800	SPEECH PATHOLOGY	0	26,857	0.000000	0.000000	2,988	68.00
69.00	06900	ELECTROCARDIOLOGY	0	822,818	0.000000	0.000000	132,809	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,895	0.000000	0.000000	8,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,644	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,321,093	0.000000	0.000000	468,271	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	5,879,512	0.000000	0.000000	857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	519,384	0.000000	0.000000	1,570	92.00
200.00		Total (lines 50-199)	0	22,478,045			1,399,598	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
51.01	05101	O/P TREATMENT ROOM	0	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
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 PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.341382	0	536,164	0	0	50.00
51.00	05100	RECOVERY ROOM	0.685650	0	27,933	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.473092	0	124,619	1,700	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170454	0	1,840,702	433	0	54.00
56.00	05600	RADIOISOTOPE	0.219801	0	87,115	19	0	56.00
60.00	06000	LABORATORY	0.182563	0	837,355	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.399092	0	3,928	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.107146	0	32,011	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.507344	0	194,868	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663311	0	49,226	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.640876	0	3,936	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.144350	0	256,117	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.050939	0	1,269	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.645999	0	8,514	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284883	0	484,081	1,058	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.189176	0	1,416,743	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804805	0	217,245	0	0	92.00
200.00		Subtotal (see instructions)		0	6,121,826	3,210	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	6,121,826	3,210	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	183,037	0		50.00
51.00	05100	RECOVERY ROOM	19,152	0		51.00
51.01	05101	O/P TREATMENT ROOM	58,956	804		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	313,755	74		54.00
56.00	05600	RADIOISOTOPE	19,148	4		56.00
60.00	06000	LABORATORY	152,870	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,496	0		62.00
65.00	06500	RESPIRATORY THERAPY	35,441	0		65.00
66.00	06600	PHYSICAL THERAPY	98,865	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	32,652	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,522	0		68.00
69.00	06900	ELECTROCARDIOLOGY	36,970	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,603	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,014	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	137,906	301		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	268,014	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	174,840	0		92.00
200.00		Subtotal (see instructions)	1,556,241	1,183		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,556,241	1,183		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.341382	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.685650	0	0	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.473092	0	0	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170454	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.219801	0	0	0	0	56.00
60.00	06000	LABORATORY	0.182563	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.399092	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.107146	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.507344	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663311	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.640876	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.144350	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.050939	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.645999	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284883	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.189176	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804805	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
51.01	05101	O/P TREATMENT ROOM	0	0		51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,106	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	978	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)	683	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	114	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	14	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)	413	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)	114	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,549,124	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)	1,808	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)	163,341	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,385,783	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)	1,385,783	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)	1,416.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	585,204	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)	585,204	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	538,764	165	3,265.24	89	290,606	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)	482,281	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,358,091	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)	161,533	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)	161,533	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)	295	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,416.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	418,003	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	138,977	1,385,783	0.100288	418,003	41,921	90.00
91.00	Nursing School cost	0	1,385,783	0.000000	418,003	0	91.00
92.00	Allied health cost	0	1,385,783	0.000000	418,003	0	92.00
93.00	All other Medical Education	0	1,385,783	0.000000	418,003	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 5:00 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)	1,106	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	978	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)	683	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	114	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	14	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)	117	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,549,124	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)	1,808	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)	163,341	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,385,783	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)	1,385,783	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)	1,416.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	165,784	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)	165,784	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 5:00 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	538,764	165	3,265.24	12	39,183	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)	119,752	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	324,719	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)	295	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,416.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	418,003	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 5:00 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	138,977	1,385,783	0.100288	418,003	41,921	90.00
91.00	Nursing School cost	0	1,385,783	0.000000	418,003	0	91.00
92.00	Allied health cost	0	1,385,783	0.000000	418,003	0	92.00
93.00	All other Medical Education	0	1,385,783	0.000000	418,003	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		635,810		30.00
31.00	03100	INTENSIVE CARE UNIT		224,920		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.341382	264,213	90,198	50.00
51.00	05100	RECOVERY ROOM	0.685650	5,718	3,921	51.00
51.01	05101	O/P TREATMENT ROOM	0.473092	2,170	1,027	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170454	136,349	23,241	54.00
56.00	05600	RADIOISOTOPE	0.219801	11,843	2,603	56.00
60.00	06000	LABORATORY	0.182563	214,418	39,145	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.399092	9,709	13,584	62.00
65.00	06500	RESPIRATORY THERAPY	1.107146	103,540	114,634	65.00
66.00	06600	PHYSICAL THERAPY	0.507344	24,837	12,601	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663311	11,698	7,759	67.00
68.00	06800	SPEECH PATHOLOGY	0.640876	2,988	1,915	68.00
69.00	06900	ELECTROCARDIOLOGY	0.144350	132,809	19,171	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.050939	8,608	17,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.645999	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284883	468,271	133,402	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.189176	857	162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804805	1,570	1,264	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,399,598	482,281	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,399,598		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.341382	739	252	50.00
51.00	05100	RECOVERY ROOM	0.685650	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.473092	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170454	1,282	219	54.00
56.00	05600	RADIOISOTOPE	0.219801	0	0	56.00
60.00	06000	LABORATORY	0.182563	6,590	1,203	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.399092	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.107146	13,326	14,754	65.00
66.00	06600	PHYSICAL THERAPY	0.507344	16,661	8,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663311	8,148	5,405	67.00
68.00	06800	SPEECH PATHOLOGY	0.640876	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.144350	464	67	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.050939	325	667	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.645999	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284883	60,561	17,253	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.189176	46	9	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804805	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		108,142	48,282	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)		108,142		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 5:00 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		143,438		30.00
31.00	03100	INTENSIVE CARE UNIT		27,760		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.341382	111,355	38,015	50.00
51.00	05100	RECOVERY ROOM	0.685650	2,718	1,864	51.00
51.01	05101	O/P TREATMENT ROOM	0.473092	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170454	80,345	13,695	54.00
56.00	05600	RADIOISOTOPE	0.219801	4,255	935	56.00
60.00	06000	LABORATORY	0.182563	73,499	13,418	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.399092	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.107146	25,248	27,953	65.00
66.00	06600	PHYSICAL THERAPY	0.507344	2,170	1,101	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663311	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.640876	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.144350	11,810	1,705	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.050939	1,602	3,286	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.645999	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284883	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.189176	93,984	17,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804805	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		406,986	119,752	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)		406,986		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 5:00 pm

Title XIX | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.341382	0	0	50.00
51.00	05100	RECOVERY ROOM	0.685650	0	0	51.00
51.01	05101	O/P TREATMENT ROOM	0.473092	0	0	51.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170454	0	0	54.00
56.00	05600	RADIOISOTOPE	0.219801	0	0	56.00
60.00	06000	LABORATORY	0.182563	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.399092	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1.107146	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.507344	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.663311	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.640876	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.144350	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.050939	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.645999	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.284883	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.189176	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804805	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151326	Period: From 09/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 5:00 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,557,424	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,557,424	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,572,998	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	4,400	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,049,676	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)	518,922	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)	518,922	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	518,922	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)	294,365	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	223,717	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	194,603	36.00
37.00	Subtotal (see instructions)	742,639	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	742,639	40.00
40.01	Sequestration adjustment (see instructions)	14,853	40.01
41.00	Interim payments	827,768	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-99,982	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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,053,237		827,768	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)		1,053,237		827,768	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		172,352		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		99,982	6.02
7.00	Total Medicare program liability (see instructions)		1,225,589		727,786	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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 5:00 pm

Component CCN: 15Z326 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		189,030		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)		189,030		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		18,645		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		207,675		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: 151326	Period: From 09/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/27/2015 5:00 pm
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet E-2 | Date/Time Prepared: 5/27/2015 5:00 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	163,148	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	48,765	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	114	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	211,913	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	211,913	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	211,913	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	211,913	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	211,913	0	19.00
19.01	Sequestration adjustment (see instructions)	4,238	0	19.01
20.00	Interim payments	189,030	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	18,645	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151326 | Component CCN: 15Z326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet E-2 | Date/Time Prepared: 5/27/2015 5:00 pm

Title XIX | Swing Beds - SNF | Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151326	Period: From 09/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/27/2015 5:00 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,358,091	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,358,091	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,371,672	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,371,672	19.00
20.00	Deductibles (exclude professional component)	152,000	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,219,672	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,219,672	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	40,696	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	30,929	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,905	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,250,601	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,250,601	30.00
30.01	Sequestration adjustment (see instructions)	25,012	30.01
31.00	Interim payments	1,053,237	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	172,352	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet E-3 Part VII | Date/Time Prepared: 5/27/2015 5:00 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	324,719		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)	324,719	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)	324,719	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	171,198		8.00
9.00	Ancillary service charges	406,986	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)	578,184	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)	578,184	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	253,465	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)	324,719	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)	324,719	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)	324,719	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)	324,719	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	324,719	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)	324,719	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	324,719	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: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/27/2015 5:00 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	2,092	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,797,519	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	276,322	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	19,356,350	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)	22,432,283	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	609,760	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	13,052,472	0	0	0	15.00
16.00	Accumulated depreciation	-10,166,156	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	5,720,047	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)	9,216,123	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,648,406	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	352,392	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,152,011	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	698,030	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,202,433	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	1,504,202	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	1,504,202	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,706,635	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	27,941,771				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)	27,941,771	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,648,406	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/27/2015 5:00 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		26,259,690		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,682,081				2.00
3.00	Total (sum of line 1 and line 2)		27,941,771		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		27,941,771		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)		27,941,771		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151326 | Period: From 09/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2015 5:00 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,635,171		1,635,171	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	97,955		97,955	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,733,126		1,733,126	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	418,469		418,469	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)	418,469		418,469	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,151,595		2,151,595	17.00
18.00	Ancillary services	3,292,733	13,325,818	16,618,551	18.00
19.00	Outpatient services	280,814	5,598,698	5,879,512	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRACTICES	0	180,863	180,863	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,725,142	19,105,379	24,830,521	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		6,326,531		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)		6,326,531		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151326	Period: From 09/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/27/2015 5:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	24,830,521	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,713,372	2.00
3.00	Net patient revenues (line 1 minus line 2)	9,117,149	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	6,326,531	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,790,618	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	122,086	24.00
24.01	TOTAL NON-OPERATING REVENUES	314	24.01
24.02	BAD DEBT	-1,230,937	24.02
25.00	Total other income (sum of lines 6-24)	-1,108,537	25.00
26.00	Total (line 5 plus line 25)	1,682,081	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)	1,682,081	29.00