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: 150104	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/28/2015 2:31 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2015 Time: 2:31 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 WITHAM MEMORIAL HOSPITAL (150104) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	64,969	76,899	53,779	-495,458	1.00
2.00	Subprovider - IPF	0	0	-181		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	64,969	76,718	53,779	-495,458	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2015 2:17 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2605 N. LEBANON STREET	PO Box:			1.00
2.00	City: LEBANON	State: IN	Zip Code: 46052-	County: BOONE	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	WITHAM MEMORIAL HOSPITAL	150104	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	WITHAM HOSPITAL GEROPSYCH	15S104	26900	4	01/01/2000	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	420	640	0	0	853	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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2015 2:17 pm

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 2:17 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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 2:17 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2015 2:17 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	147,695	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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 2:17 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)	N		140.00

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	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)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150104	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 2:17 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)	10/01/2013	09/30/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2015 2:17 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/24/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/28/2015 2:17 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?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA	SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946	TSEVERS@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2015 2:17 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/24/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2015 2:17 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	60	21,900	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		60	21,900	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		68	24,820	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY						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)		78				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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2015 2:17 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)	2,255	417	5,150			1.00
2.00	HMO and other (see instructions)	707	1,437				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,255	417	5,150			7.00
8.00	INTENSIVE CARE UNIT	763	0	1,487			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	997			13.00
14.00	Total (see instructions)	3,018	417	7,634	0.00	560.56	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,474	0	2,987	0.00	20.33	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						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	580.89	27.00
28.00	Observation Bed Days		0	1,146			28.00
29.00	Ambulance Trips	347					29.00
30.00	Employee discount days (see instruction)			93			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	59	88			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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2015 2:17 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	163	152	2,247	1.00
2.00	HMO and other (see instructions)			210	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	163	152	2,247	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	37	0	207	16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/28/2015 2:17 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	38,423,454	1,928,665	40,352,119	1,208,260.00	33.40	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		15,531,968	1,535,290	17,067,258	391,505.00	43.59	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		384,972	0	384,972	4,482.00	85.89	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,805,929	0	8,805,929			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		4,468,912	0	4,468,912			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,241,540	5,073	1,246,613	9,124.00	136.63	26.00
27.00	Administrative & General	5.00	4,698,765	196,179	4,894,944	171,775.00	28.50	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	519,471	9,078	528,549	20,223.00	26.14	30.00
31.00	Laundry & Linen Service	8.00	22,322	534	22,856	2,117.00	10.80	31.00
32.00	Housekeeping	9.00	330,914	7,532	338,446	26,576.00	12.74	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	643,108	-299,011	344,097	14,968.00	22.99	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	309,237	309,237	26,406.00	11.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	446,153	6,055	452,208	11,601.00	38.98	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	398,168	3,868	402,036	12,267.00	32.77	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/28/2015 2:17 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	839,349	15,775	855,124	36,127.00	23.67	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/28/2015 2:17 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		38,423,454	1,928,665	40,352,119	1,208,260.00	33.40	1.00
2.00	Excluded area salaries (see instructions)		15,531,968	1,535,290	17,067,258	391,505.00	43.59	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,891,486	393,375	23,284,861	816,755.00	28.51	3.00
4.00	Subtotal other wages & related costs (see inst.)		384,972	0	384,972	4,482.00	85.89	4.00
5.00	Subtotal wage-related costs (see inst.)		8,805,929	0	8,805,929	0.00	37.82	5.00
6.00	Total (sum of lines 3 thru 5)		32,082,387	393,375	32,475,762	821,237.00	39.54	6.00
7.00	Total overhead cost (see instructions)		9,139,790	254,320	9,394,110	331,184.00	28.37	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/28/2015 2:17 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,597,908	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	8,551,023	8.00
9.00	Prescription Drug Plan	175,632	9.00
10.00	Dental, Hearing and Vision Plan	-68,186	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	56,634	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	147,083	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	410,596	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,390,180	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	10,613	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,271,483	24.00
	Part B - Other than Core Related Cost		
25.00	MORALE FUND / RECOGNITION	72,058	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V | Date/Time Prepared: 5/28/2015 2:17 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150104	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/28/2015 2:17 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)	0.234492	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,917,063	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?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	27,602,225	6.00
7.00	Medicaid cost (line 1 times line 6)	6,472,501	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	5,005,783	0	5,005,783	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,173,816	0	1,173,816	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,173,816	0	1,173,816	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)	13,869,697	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	102,742	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	13,766,955	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,228,241	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,402,057	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,402,057	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/28/2015 2:17 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		1,736,039	1,736,039	156,153	1,892,192	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	2,706,904	2,706,904	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,241,540	10,770,047	12,011,587	-1,689,414	10,322,173	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,698,765	16,052,232	20,750,997	-776,366	19,974,631	5.00
7.00	00700	OPERATION OF PLANT	519,471	2,906,632	3,426,103	-59,611	3,366,492	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,322	222,919	245,241	511	245,752	8.00
9.00	00900	HOUSEKEEPING	330,914	150,744	481,658	5,814	487,472	9.00
10.00	01000	DIETARY	643,108	654,958	1,298,066	-695,923	602,143	10.00
11.00	01100	CAFETERIA	0	0	0	701,941	701,941	11.00
13.00	01300	NURSING ADMINISTRATION	446,153	37,918	484,071	4,416	488,487	13.00
15.00	01500	PHARMACY	398,168	2,031,986	2,430,154	-1,119,911	1,310,243	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	839,349	312,918	1,152,267	11,375	1,163,642	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,607,985	745,967	3,353,952	-148,559	3,205,393	30.00
31.00	03100	INTENSIVE CARE UNIT	921,548	218,594	1,140,142	-59,122	1,081,020	31.00
40.00	04000	SUBPROVIDER - IPF	1,060,759	248,196	1,308,955	6,155	1,315,110	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	42,950	42,950	0	42,950	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,782,925	5,571,254	7,354,179	-6,126,924	1,227,255	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	989,329	2,139,428	3,128,757	-190,059	2,938,698	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	262,283	161,472	423,755	-44,456	379,299	55.01
57.00	05700	CT SCAN	108,736	1,021,586	1,130,322	-498,435	631,887	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	277,738	876,965	1,154,703	-423,483	731,220	58.00
59.00	05900	CARDIAC CATHETERIZATION	155,871	427,379	583,250	-270,052	313,198	59.00
60.00	06000	LABORATORY	1,809,469	3,184,631	4,994,100	-150,163	4,843,937	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	135,539	135,539	0	135,539	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	969,054	211,128	1,180,182	-4,668	1,175,514	66.00
67.00	06700	OCCUPATIONAL THERAPY	369,309	242,674	611,983	3,358	615,341	67.00
67.01	06701	AUDIOLOGY	146,968	205,347	352,315	-13,985	338,330	67.01
68.00	06800	SPEECH PATHOLOGY	61,343	5,060	66,403	648	67,051	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	684,516	169,617	854,133	-26,866	827,267	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,691	19,691	1,958,500	1,978,191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	4,726,493	4,726,493	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,015,548	1,015,548	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	174,881	123,458	298,339	-6,588	291,751	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	1,507	1,507	0	1,507	90.03
90.04	09004	ENT CLINIC	0	35	35	0	35	90.04
90.05	09005	SURGERY CLINIC	0	1,152	1,152	-653	499	90.05
90.07	09007	UROLOGY CLINIC	0	5,125	5,125	-3,456	1,669	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	21	8,665	8,686	1,068	9,754	90.09
90.11	09011	NEUROLOGY CLINIC	0	4,447	4,447	-3,323	1,124	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	59,759	59,759	-41,955	17,804	90.12
90.13	09013	ALLERGY CLINIC	72,197	44,931	117,128	-115	117,013	90.13
90.14	09014	WOUND CARE	204,874	162,613	367,487	-24,425	343,062	90.14
91.00	09100	EMERGENCY	2,152,649	2,311,663	4,464,312	-196,859	4,267,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,265,960	374,470	1,640,430	-124,639	1,515,791	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,218,205	53,601,696	78,819,901	-1,401,126	77,418,775	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,177,148	5,439,088	18,616,236	1,400,924	20,017,160	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	-332	-332	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	28,101	102,111	130,212	534	130,746	194.02
200.00		TOTAL (SUM OF LINES 118-199)	38,423,454	59,142,895	97,566,349	0	97,566,349	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/28/2015 2:17 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	-597,859	1,294,333		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,706,904		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,479,802	6,842,371		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-914,504	19,060,127		5.00
7.00	00700	OPERATION OF PLANT	-50	3,366,442		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	245,752		8.00
9.00	00900	HOUSEKEEPING	0	487,472		9.00
10.00	01000	DIETARY	-76,724	525,419		10.00
11.00	01100	CAFETERIA	-213,039	488,902		11.00
13.00	01300	NURSING ADMINISTRATION	0	488,487		13.00
15.00	01500	PHARMACY	0	1,310,243		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,163,642		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,205,393		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,081,020		31.00
40.00	04000	SUBPROVIDER - IPF	-47,755	1,267,355		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	42,950		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-833,000	394,255		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-222	2,938,476		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	379,299		55.01
57.00	05700	CT SCAN	0	631,887		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	731,220		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	313,198		59.00
60.00	06000	LABORATORY	-252,500	4,591,437		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	135,539		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	1,175,514		66.00
67.00	06700	OCCUPATIONAL THERAPY	-3,767	611,574		67.00
67.01	06701	AUDIOLOGY	-205,821	132,509		67.01
68.00	06800	SPEECH PATHOLOGY	0	67,051		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	-10,712	816,555		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-113,628	1,864,563		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,726,493		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-26,311	989,237		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	291,751		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	-1,507	0		90.03
90.04	09004	ENT CLINIC	0	35		90.04
90.05	09005	SURGERY CLINIC	-499	0		90.05
90.07	09007	UROLOGY CLINIC	-1,669	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	-9,754	0		90.09
90.11	09011	NEUROLOGY CLINIC	-1,124	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	17,804		90.12
90.13	09013	ALLERGY CLINIC	0	117,013		90.13
90.14	09014	WOUND CARE	0	343,062		90.14
91.00	09100	EMERGENCY	-1,459,050	2,808,403		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-685	1,515,106		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,249,982	69,168,793		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,017,160		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	-332		194.00
194.01	07951	CAFE/BOUTIQUE	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	130,746		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,249,982	89,316,367		200.00

RECLASSIFICATIONS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/28/2015 2:17 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	236,493		1.00
	TOTALS		0	236,493		
	B - INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	176,318		1.00
	TOTALS		0	176,318		
	C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	309,237	392,704		1.00
	TOTALS		309,237	392,704		
	D - MME DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,706,904		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
	TOTALS		0	2,706,904		
	E - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,117,693		1.00
	TOTALS		0	1,117,693		
	F - MED SUPPLY IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	4,726,493		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	4,726,493		
	G - CHARGABLE MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,975,200		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00

RECLASSIFICATIONS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/28/2015 2:17 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	TOTALS		0	1,975,200	
	H - BONUS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,073	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	196,179	0	2.00
3.00	OPERATION OF PLANT	7.00	9,078	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	534	0	4.00
5.00	HOUSEKEEPING	9.00	7,532	0	5.00
6.00	DIETARY	10.00	10,226	0	6.00
7.00	NURSING ADMINISTRATION	13.00	6,055	0	7.00
8.00	PHARMACY	15.00	3,868	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	15,775	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	21,777	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	8,419	0	11.00
12.00	SUBPROVIDER - IPF	40.00	12,217	0	12.00
13.00	OPERATING ROOM	50.00	17,023	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	15,306	0	14.00
15.00	ULTRA SOUND	55.01	2,153	0	15.00
16.00	CT SCAN	57.00	801	0	16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	2,314	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	1,246	0	18.00
19.00	LABORATORY	60.00	21,790	0	19.00
20.00	PHYSICAL THERAPY	66.00	8,794	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	7,230	0	21.00
22.00	AUDIOLOGY	67.01	1,578	0	22.00
23.00	SPEECH PATHOLOGY	68.00	712	0	23.00
24.00	CARDIOLOGY	69.01	5,539	0	24.00
25.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	3,382	0	25.00
26.00	GASTROENTEROLOGY CLINIC	90.09	1,068	0	26.00
27.00	ALLERGY CLINIC	90.13	1,068	0	27.00
28.00	WOUND CARE	90.14	4,094	0	28.00
29.00	EMERGENCY	91.00	14,761	0	29.00
30.00	AMBULANCE SERVICES	95.00	13,500	0	30.00
31.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,509,039	0	31.00
32.00	OTHER NONREIMBURSABLE COST CENTERS	194.02	534	0	32.00
	TOTALS		1,928,665	0	
500.00	Grand Total: Increases		2,237,902	11,331,805	500.00

RECLASSIFICATIONS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/28/2015 2:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	236,493	0		1.00
	TOTALS		0	236,493			
	B - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	176,318	12		1.00
	TOTALS		0	176,318			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	309,237	392,704	0		1.00
	TOTALS		309,237	392,704			
	D - MME DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	20,165	9		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,315	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	559,734	0		3.00
4.00	OPERATION OF PLANT	7.00	0	68,689	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	0	23	0		5.00
6.00	HOUSEKEEPING	9.00	0	1,718	0		6.00
7.00	DIETARY	10.00	0	4,208	0		7.00
8.00	NURSING ADMINISTRATION	13.00	0	1,639	0		8.00
9.00	PHARMACY	15.00	0	1,492	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,400	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	70,027	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	17,778	0		12.00
13.00	SUBPROVIDER - IPF	40.00	0	1,735	0		13.00
14.00	OPERATING ROOM	50.00	0	246,935	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	146,251	0		15.00
16.00	ULTRA SOUND	55.01	0	45,270	0		16.00
17.00	CT SCAN	57.00	0	494,405	0		17.00
18.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	425,563	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	26,619	0		19.00
20.00	LABORATORY	60.00	0	171,184	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	13,452	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	3,473	0		22.00
23.00	AUDIOLOGY	67.01	0	15,563	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	64	0		24.00
25.00	CARDIOLOGY	69.01	0	31,218	0		25.00
26.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	65	0		26.00
27.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	7,409	0		27.00
28.00	SURGERY CLINIC	90.05	0	653	0		28.00
29.00	UROLOGY CLINIC	90.07	0	3,198	0		29.00
30.00	NEUROLOGY CLINIC	90.11	0	3,323	0		30.00
31.00	OPTHAMOLOGY CLINIC	90.12	0	41,955	0		31.00
32.00	ALLERGY CLINIC	90.13	0	939	0		32.00
33.00	WOUND CARE	90.14	0	6,404	0		33.00
34.00	EMERGENCY	91.00	0	29,506	0		34.00
35.00	AMBULANCE SERVICES	95.00	0	131,890	0		35.00
36.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	107,310	0		36.00
37.00	THORNTOWN OFFICE BUILDING	194.00	0	332	0		37.00
	TOTALS		0	2,706,904			
	E - DRUGS RECLASS						
1.00	PHARMACY	15.00	0	1,117,693	0		1.00
	TOTALS		0	1,117,693			
	F - MED SUPPLY IMPLANTS						
1.00	ADULTS & PEDIATRICS	30.00	0	2,142	0		1.00
2.00	OPERATING ROOM	50.00	0	4,307,018	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	58,487	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	241,672	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,761	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	102,145	0		6.00
7.00	WOUND CARE	90.14	0	5,268	0		7.00
	TOTALS		0	4,726,493			
	G - CHARGABLE MED SUPPLIES						
1.00	PHARMACY	15.00	0	4,594	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	98,167	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	49,763	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	4,327	0		4.00
5.00	OPERATING ROOM	50.00	0	1,589,994	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	627	0		6.00
7.00	ULTRA SOUND	55.01	0	1,339	0		7.00
8.00	CT SCAN	57.00	0	4,831	0		8.00

RECLASSIFICATIONS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/28/2015 2:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	234	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	3,007	0		10.00
11.00	LABORATORY	60.00	0	769	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	10	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	399	0		13.00
14.00	CARDIOLOGY	69.01	0	1,187	0		14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,874	0		15.00
16.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	2,561	0		16.00
17.00	UROLOGY CLINIC	90.07	0	258	0		17.00
18.00	ALLERGY CLINIC	90.13	0	244	0		18.00
19.00	WOUND CARE	90.14	0	16,847	0		19.00
20.00	EMERGENCY	91.00	0	182,114	0		20.00
21.00	AMBULANCE SERVICES	95.00	0	6,249	0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	805	0		22.00
	TOTALS		0	1,975,200			
	H - BONUS RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,928,665	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
	TOTALS		0	1,928,665			
500.00	Grand Total: Decreases		309,237	13,260,470			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2015 2:17 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	7,721,719	5,270,585	0	5,270,585	0	2.00
3.00	Buildings and Fixtures	76,044,243	6,172,915	0	6,172,915	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,235,789	4,706	0	4,706	0	5.00
6.00	Movable Equipment	37,769,977	4,934,925	0	4,934,925	300,342	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	123,771,728	16,383,131	0	16,383,131	300,342	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	123,771,728	16,383,131	0	16,383,131	300,342	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	12,992,304	0	2.00
3.00	Buildings and Fixtures	82,217,158	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,240,495	0	5.00
6.00	Movable Equipment	42,404,560	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139,854,517	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	139,854,517	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2015 2:17 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	1,736,039	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,736,039	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	1,736,039		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	1,736,039		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2015 2:17 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	82,217,158	0	82,217,158	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	82,217,158	0	82,217,158	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	1,715,874	-63,136	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,706,904	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,422,778	-63,136	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	-534,723	176,318	0	0	1,294,333	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,706,904	2.00
3.00	Total (sum of lines 1-2)	-534,723	176,318	0	0	4,001,237	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/28/2015 2:17 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)	B	-5,106	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,594,572			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-213,039	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-4,078	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - 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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/28/2015 2:17 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	HOSPTIAL ADMIN SPONSORSHIPS/DONATION	A	-207,716	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01			0		0.00	0	33.01
33.02	LEASE INCOME	B	-25,906	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	RENTAL REVENUE	B	-27,030	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.03
33.04	MEDICAL STAFF FEES	B	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	EMPLOYEE RECORD FEES	B	-50	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PATIENT ACCOUNTS	B	-6,154	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC INCOME RECEIVED	B	-583	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEALS ON WHEELS	B	-46,887	DIETARY	10.00	0	33.08
33.09	DIETARY TAX REVENUE	B	819	DIETARY	10.00	0	33.09
33.10	XRAY FEES	B	-222	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	DEMATOLOGY CLINIC RENT	B	-1,507	DERMATOLOGY CLINIC	90.03	0	33.11
33.12	SURGERY CLINIC RENT	B	-499	SURGERY CLINIC	90.05	0	33.12
33.13	CARDIOLOGY	B	-10,712	CARDIOLOGY	69.01	0	33.13
33.14	UROLOGY CLINIC RENT	B	-1,669	UROLOGY CLINIC	90.07	0	33.14
33.15	GASTROENTEROLOGY CLINIC RENT	B	-9,754	GASTROENTEROLOGY CLINIC	90.09	0	33.15
33.16	NEUROLOGY CLINIC RENT	B	-1,124	NEUROLOGY CLINIC	90.11	0	33.16
33.17	AMBULANCE	B	-685	AMBULANCE SERVICES	95.00	0	33.17
33.18			0		0.00	0	33.18
33.19	2005 PREMIUM AMORTIZATION	B	-134,258	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.19
33.20	2010 PREMIUM AMORTIZATION	B	-24,133	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.20
33.21	2005 BOND GAIN/LOSS ON INVESTMENT	B	-18,870	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.21
33.22	2005 BOND INTEREST ON INVEST	B	-27,377	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.22
33.23	2010 BOND INTEREST ON INVEST	B	-1,231	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.23
33.24	LOSS ON INVESTMENT	B	-102,686	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.24
33.25	GAIN/LOSS SHO INV	B	-82,128	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26	GAIN/LOSS CIHA	B	-40,242	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	GAIN/LOSS SHO RRG	B	-5,079	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28			0		0.00	0	33.28
33.29	HEARING AID COSTS	A	-205,821	AUDIOLOGY	67.01	0	33.29
33.30	PHYSICIAN RECRUITMENT	A	-60,417	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.31	BANK FEES	A	-169,487	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	LOBBYING EXPENSE IHHA DUES	A	-1,496	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	LOBBYING EXPENSE AHA DUES	A	-4,048	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	NONREIMBURSABLE ADVERTISING COST	A	-328,998	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35			0		0.00	0	33.35
33.36	CENTRAL SUPPLY PURCHASING DISCOUNTS	B	-113,628	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.36
33.37	PHARMACY ED	B	-26,311	DRUGS CHARGED TO PATIENTS	73.00	0	33.37
33.38	HEAD START	B	-24,749	DIETARY	10.00	0	33.38
33.39	WELLNESS REVENUE	B	-61,769	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.39
33.40	INTEREST INCOME-UNNECESSARY BORROWIN	B	-226,168	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.40
33.41	1208 N LEBANON RENTAL INCOME	B	-10,200	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	33.41
33.42	ANSON OTHER OPERATING REVENUE	B	-50	OPERATION OF PLANT	7.00	0	33.42
33.43	LAB CLINICAL RENTAL REVENUE	B	-1,500	LABORATORY	60.00	0	33.43
33.44	CICOA MEAL VOUCHERS	B	-1,829	DIETARY	10.00	0	33.44
33.45			0		0.00	0	33.45
33.46	SELF INSURANCE CLAIMS PAID	A	-3,418,033	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.47
33.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.48
33.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.49
33.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.50

ADJUSTMENTS TO EXPENSES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/28/2015 2:17 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	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,249,982				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2015 2:17 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	40.00	SUBPROVIDER - IPF	112,210	0	112,210	154,100	870	1.00
2.00	50.00	OPERATING ROOM	833,000	833,000	0	0	0	2.00
3.00	60.00	LABORATORY	251,000	251,000	0	0	0	3.00
4.00	67.00	OCCUPATIONAL THERAPY	3,767	3,767	0	0	0	4.00
5.00	91.00	EMERGENCY	1,459,050	1,459,050	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			2,659,027	2,546,817	112,210		870	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	40.00	SUBPROVIDER - IPF	64,455	3,223	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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			64,455	3,223	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	40.00	SUBPROVIDER - IPF	0	64,455	47,755	47,755		1.00
2.00	50.00	OPERATING ROOM	0	0	0	833,000		2.00
3.00	60.00	LABORATORY	0	0	0	251,000		3.00
4.00	67.00	OCCUPATIONAL THERAPY	0	0	0	3,767		4.00
5.00	91.00	EMERGENCY	0	0	0	1,459,050		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	64,455	47,755	2,594,572		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,294,333	1,294,333				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,706,904		2,706,904			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,842,371	2,944	6,156	6,851,471		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,060,127	94,076	196,745	857,619	20,208,567	5.00
7.00	00700	OPERATION OF PLANT	3,366,442	123,249	257,757	92,604	3,840,052	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	245,752	0	0	4,004	249,756	8.00
9.00	00900	HOUSEKEEPING	487,472	14,192	29,681	59,297	590,642	9.00
10.00	01000	DIETARY	525,419	31,768	66,438	60,288	683,913	10.00
11.00	01100	CAFETERIA	488,902	0	0	54,180	543,082	11.00
13.00	01300	NURSING ADMINISTRATION	488,487	0	0	79,229	567,716	13.00
15.00	01500	PHARMACY	1,310,243	9,807	20,510	70,439	1,410,999	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,163,642	15,492	32,399	149,822	1,361,355	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,205,393	103,043	215,499	460,747	3,984,682	30.00
31.00	03100	INTENSIVE CARE UNIT	1,081,020	28,299	59,182	162,935	1,331,436	31.00
40.00	04000	SUBPROVIDER - IPF	1,267,355	32,400	67,761	187,991	1,555,507	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	42,950	0	0	0	42,950	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	394,255	82,240	171,993	315,360	963,848	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,938,476	100,580	210,348	176,017	3,425,421	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	379,299	0	0	46,331	425,630	55.01
57.00	05700	CT SCAN	631,887	0	0	19,191	651,078	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	731,220	8,629	18,046	49,067	806,962	58.00
59.00	05900	CARDIAC CATHETERIZATION	313,198	7,273	15,211	27,528	363,210	59.00
60.00	06000	LABORATORY	4,591,437	46,906	98,097	320,846	5,057,286	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	135,539	0	0	0	135,539	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,175,514	45,399	94,945	171,324	1,487,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	611,574	0	0	65,972	677,546	67.00
67.01	06701	AUDIOLOGY	132,509	0	0	26,026	158,535	67.01
68.00	06800	SPEECH PATHOLOGY	67,051	0	0	10,872	77,923	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	816,555	4,678	9,784	120,901	951,918	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,864,563	0	0	0	1,864,563	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,726,493	0	0	0	4,726,493	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	989,237	0	0	0	989,237	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	291,751	19,331	40,428	31,233	382,743	90.01
90.02	09002	CLINIC	0	31,080	65,000	0	96,080	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	35	0	0	0	35	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	191	191	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	17,804	0	0	0	17,804	90.12
90.13	09013	ALLERGY CLINIC	117,013	0	0	12,836	129,849	90.13
90.14	09014	WOUND CARE	343,062	17,723	37,064	36,612	434,461	90.14
91.00	09100	EMERGENCY	2,808,403	124,251	259,851	379,741	3,572,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,515,106	24,075	50,350	224,168	1,813,699	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,168,793	967,435	2,023,245	4,273,371	65,580,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,156	6,600	0	9,756	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,017,160	210,649	440,542	2,573,083	23,241,434	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	-332	0	0	0	-332	194.00
194.01	07951	CAFE/BOUTIQUE	0	9,185	19,209	0	28,394	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	130,746	103,908	217,308	5,017	456,979	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)	89,316,367	1,294,333	2,706,904	6,851,471	89,316,367	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	20,208,567					5.00
7.00	00700	OPERATION OF PLANT	1,122,908	4,962,960				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,034	0	322,790			8.00
9.00	00900	HOUSEKEEPING	172,716	75,762	0	839,120		9.00
10.00	01000	DIETARY	199,990	169,587	0	52,028	1,105,518	10.00
11.00	01100	CAFETERIA	158,808	0	0	17,347	0	11.00
13.00	01300	NURSING ADMINISTRATION	166,012	0	0	7,844	0	13.00
15.00	01500	PHARMACY	412,604	52,353	0	15,838	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	398,087	82,701	0	34,694	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,165,201	550,072	18,124	263,554	599,094	30.00
31.00	03100	INTENSIVE CARE UNIT	389,339	151,065	4,412	69,991	168,779	31.00
40.00	04000	SUBPROVIDER - IPF	454,861	172,962	4,028	83,228	337,645	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	12,559	0	1,880	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	281,848	439,021	48,565	15,537	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,001,662	536,923	24,877	70,292	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	124,463	0	9,308	4,525	0	55.01
57.00	05700	CT SCAN	190,388	0	37,002	6,939	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	235,972	46,062	14,941	6,637	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	106,210	38,826	4,001	0	0	59.00
60.00	06000	LABORATORY	1,478,852	250,398	55,993	29,716	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	39,634	0	1,101	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	2,763	0	0	64.00
66.00	06600	PHYSICAL THERAPY	434,882	242,352	7,022	10,710	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	198,128	0	1,493	5,129	0	67.00
67.01	06701	AUDIOLOGY	46,359	0	1,022	3,771	0	67.01
68.00	06800	SPEECH PATHOLOGY	22,786	0	521	2,263	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	278,360	24,975	12,030	22,777	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	545,236	0	5,678	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,382,121	0	6,400	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	289,273	0	15,099	16,442	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	111,922	103,194	0	40,426	0	90.01
90.02	09002	CLINIC	28,096	165,915	0	59,432	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	10	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	169	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	56	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	748	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	5,206	0	100	0	0	90.12
90.13	09013	ALLERGY CLINIC	37,970	0	1,685	0	0	90.13
90.14	09014	WOUND CARE	127,045	94,608	2,855	0	0	90.14
91.00	09100	EMERGENCY	1,044,596	663,283	33,986	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	530,362	47,520	6,987	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,267,556	3,907,579	322,790	839,120	1,105,518	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,853	16,848	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,796,225	989,501	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	8,303	49,032	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	133,630	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)	20,208,567	4,962,960	322,790	839,120	1,105,518	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	719,237					11.00
13.00	01300	NURSING ADMINISTRATION	13,916	755,488				13.00
15.00	01500	PHARMACY	27,832	0	1,919,626			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56,396	0	0	1,933,233		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	189,697	167,164	5,323	475,077	7,417,988	30.00
31.00	03100	INTENSIVE CARE UNIT	15,381	51,960	675	98,778	2,281,816	31.00
40.00	04000	SUBPROVIDER - IPF	24,170	85,169	169	117,593	2,835,332	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	57,389	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,846	131,480	34,388	170,510	2,102,043	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,508	0	3,253	456,262	5,539,198	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	2,197	0	2,302	49,389	617,814	55.01
57.00	05700	CT SCAN	2,930	0	3,584	56,445	948,366	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,324	0	5,666	30,574	1,154,138	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,198	41	0	522,486	59.00
60.00	06000	LABORATORY	60,058	0	396	47,037	6,979,736	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	176,274	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	2,763	64.00
66.00	06600	PHYSICAL THERAPY	30,029	54,073	10,644	91,723	2,368,617	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,451	24,077	0	39,982	958,806	67.00
67.01	06701	AUDIOLOGY	13,184	11,653	0	0	234,524	67.01
68.00	06800	SPEECH PATHOLOGY	13,916	0	49,107	0	166,516	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	30,029	45,607	125	88,195	1,454,016	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,381	0	0	0	2,430,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	6,115,014	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,310,051	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	24,902	11,618	0	197,557	872,362	90.01
90.02	09002	CLINIC	0	0	0	0	349,523	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	45	90.04
90.05	09005	SURGERY CLINIC	0	0	84	0	84	90.05
90.07	09007	UROLOGY CLINIC	0	0	1,544	0	1,713	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	10,346	72	0	10,665	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	24	0	772	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	676	0	23,786	90.12
90.13	09013	ALLERGY CLINIC	0	7,389	1,878	0	178,771	90.13
90.14	09014	WOUND CARE	46,875	15,646	5,518	0	727,008	90.14
91.00	09100	EMERGENCY	0	125,599	122,928	0	5,562,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	95,215	0	15,327	0	2,509,110	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	719,237	751,979	263,724	1,919,122	55,910,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	29,457	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,220	1,655,902	14,111	32,700,393	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	-332	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	85,729	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	289	0	0	590,898	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)	719,237	755,488	1,919,626	1,933,233	89,316,367	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,417,988		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,281,816		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,835,332		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	57,389		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,102,043		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,539,198		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	617,814		55.01
57.00	05700	CT SCAN	0	948,366		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,154,138		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	522,486		59.00
60.00	06000	LABORATORY	0	6,979,736		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	176,274		63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,763		64.00
66.00	06600	PHYSICAL THERAPY	0	2,368,617		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	958,806		67.00
67.01	06701	AUDIOLOGY	0	234,524		67.01
68.00	06800	SPEECH PATHOLOGY	0	166,516		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	1,454,016		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,430,858		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,115,014		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,310,051		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	872,362		90.01
90.02	09002	CLINIC	0	349,523		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	45		90.04
90.05	09005	SURGERY CLINIC	0	84		90.05
90.07	09007	UROLOGY CLINIC	0	1,713		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	10,665		90.09
90.11	09011	NEUROLOGY CLINIC	0	772		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	23,786		90.12
90.13	09013	ALLERGY CLINIC	0	178,771		90.13
90.14	09014	WOUND CARE	0	727,008		90.14
91.00	09100	EMERGENCY	0	5,562,638		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,509,110		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	55,910,222		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	29,457		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	32,700,393		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	-332		194.00
194.01	07951	CAFE/BOUTIQUE	0	85,729		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	590,898		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	89,316,367		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/28/2015 2:17 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	2,944	6,156	9,100	9,100	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	94,076	196,745	290,821	1,141	5.00
7.00	00700	OPERATION OF PLANT	0	123,249	257,757	381,006	123	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	5	8.00
9.00	00900	HOUSEKEEPING	0	14,192	29,681	43,873	79	9.00
10.00	01000	DIETARY	0	31,768	66,438	98,206	80	10.00
11.00	01100	CAFETERIA	0	0	0	0	72	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	105	13.00
15.00	01500	PHARMACY	0	9,807	20,510	30,317	94	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,492	32,399	47,891	199	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	103,043	215,499	318,542	613	30.00
31.00	03100	INTENSIVE CARE UNIT	0	28,299	59,182	87,481	217	31.00
40.00	04000	SUBPROVIDER - IPF	0	32,400	67,761	100,161	250	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	82,240	171,993	254,233	419	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100,580	210,348	310,928	234	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	62	55.01
57.00	05700	CT SCAN	0	0	0	0	26	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,629	18,046	26,675	65	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,273	15,211	22,484	37	59.00
60.00	06000	LABORATORY	0	46,906	98,097	145,003	427	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	45,399	94,945	140,344	228	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	88	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	35	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	14	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	4,678	9,784	14,462	161	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	19,331	40,428	59,759	42	90.01
90.02	09002	CLINIC	0	31,080	65,000	96,080	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	17	90.13
90.14	09014	WOUND CARE	0	17,723	37,064	54,787	49	90.14
91.00	09100	EMERGENCY	0	124,251	259,851	384,102	505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	24,075	50,350	74,425	298	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	967,435	2,023,245	2,990,680	5,685	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,156	6,600	9,756	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	210,649	440,542	651,191	3,408	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	9,185	19,209	28,394	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	103,908	217,308	321,216	7	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	1,294,333	2,706,904	4,001,237	9,100	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	291,962					5.00
7.00	00700	OPERATION OF PLANT	16,224	397,353				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,055	0	1,060			8.00
9.00	00900	HOUSEKEEPING	2,495	6,066	0	52,513		9.00
10.00	01000	DIETARY	2,890	13,578	0	3,256	118,010	10.00
11.00	01100	CAFETERIA	2,295	0	0	1,086	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,399	0	0	491	0	13.00
15.00	01500	PHARMACY	5,961	4,192	0	991	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,752	6,621	0	2,171	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,835	44,041	54	16,494	63,951	30.00
31.00	03100	INTENSIVE CARE UNIT	5,625	12,095	13	4,380	18,017	31.00
40.00	04000	SUBPROVIDER - IPF	6,572	13,848	12	5,209	36,042	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	181	0	6	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,072	35,150	143	972	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,472	42,988	73	4,399	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	1,798	0	27	283	0	55.01
57.00	05700	CT SCAN	2,751	0	109	434	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,409	3,688	44	415	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,535	3,109	12	0	0	59.00
60.00	06000	LABORATORY	21,367	20,048	273	1,860	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	573	0	3	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	8	0	0	64.00
66.00	06600	PHYSICAL THERAPY	6,283	19,404	21	670	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,863	0	4	321	0	67.00
67.01	06701	AUDIOLOGY	670	0	3	236	0	67.01
68.00	06800	SPEECH PATHOLOGY	329	0	2	142	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	4,022	2,000	36	1,425	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,878	0	17	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,969	0	19	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,180	0	45	1,029	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	1,617	8,262	0	2,530	0	90.01
90.02	09002	CLINIC	406	13,284	0	3,719	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	1	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	2	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	75	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	549	0	5	0	0	90.13
90.14	09014	WOUND CARE	1,836	7,575	8	0	0	90.14
91.00	09100	EMERGENCY	15,093	53,105	100	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,663	3,805	21	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	191,695	312,859	1,060	52,513	118,010	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	41	1,349	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	98,175	79,219	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	120	3,926	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	1,931	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)	291,962	397,353	1,060	52,513	118,010	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	3,453					11.00
13.00	01300	NURSING ADMINISTRATION	67	3,062				13.00
15.00	01500	PHARMACY	134	0	41,689			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	271	0	0	62,905		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	910	678	116	15,458	477,692	30.00
31.00	03100	INTENSIVE CARE UNIT	74	211	15	3,214	131,342	31.00
40.00	04000	SUBPROVIDER - IPF	116	345	4	3,826	166,385	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	187	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	81	533	747	5,548	301,898	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	98	0	71	14,846	388,109	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	11	0	50	1,607	3,838	55.01
57.00	05700	CT SCAN	14	0	78	1,837	5,249	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	35	0	123	995	35,449	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	41	1	0	27,219	59.00
60.00	06000	LABORATORY	288	0	9	1,531	190,806	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	576	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	8	64.00
66.00	06600	PHYSICAL THERAPY	144	219	231	2,985	170,529	66.00
67.00	06700	OCCUPATIONAL THERAPY	60	98	0	1,301	4,735	67.00
67.01	06701	AUDIOLOGY	63	47	0	0	1,054	67.01
68.00	06800	SPEECH PATHOLOGY	67	0	1,066	0	1,620	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	144	185	3	2,870	25,308	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	74	0	0	0	7,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	19,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,254	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	120	47	0	6,428	78,805	90.01
90.02	09002	CLINIC	0	0	0	0	113,489	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	2	0	2	90.05
90.07	09007	UROLOGY CLINIC	0	0	34	0	34	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	42	2	0	45	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	1	0	3	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	15	0	90	90.12
90.13	09013	ALLERGY CLINIC	0	30	41	0	642	90.13
90.14	09014	WOUND CARE	225	63	120	0	64,663	90.14
91.00	09100	EMERGENCY	0	509	2,670	0	456,084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	457	0	333	0	87,002	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,453	3,048	5,732	62,446	2,766,074	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	11,146	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13	35,957	459	868,422	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	32,440	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	1	0	0	323,155	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)	3,453	3,062	41,689	62,905	4,001,237	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	477,692		30.00
31.00	03100	INTENSIVE CARE UNIT	0	131,342		31.00
40.00	04000	SUBPROVIDER - IPF	0	166,385		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	187		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	301,898		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	388,109		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	3,838		55.01
57.00	05700	CT SCAN	0	5,249		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	35,449		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	27,219		59.00
60.00	06000	LABORATORY	0	190,806		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	576		63.00
64.00	06400	INTRAVENOUS THERAPY	0	8		64.00
66.00	06600	PHYSICAL THERAPY	0	170,529		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,735		67.00
67.01	06701	AUDIOLOGY	0	1,054		67.01
68.00	06800	SPEECH PATHOLOGY	0	1,620		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	25,308		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,969		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	19,988		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,254		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	78,805		90.01
90.02	09002	CLINIC	0	113,489		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	2		90.05
90.07	09007	UROLOGY CLINIC	0	34		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	45		90.09
90.11	09011	NEUROLOGY CLINIC	0	3		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	90		90.12
90.13	09013	ALLERGY CLINIC	0	642		90.13
90.14	09014	WOUND CARE	0	64,663		90.14
91.00	09100	EMERGENCY	0	456,084		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	87,002		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,766,074		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11,146		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	868,422		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	32,440		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	323,155		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	4,001,237		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	255,907					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		255,907				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	582	582	39,105,506			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,600	18,600	4,894,944	-20,208,567	69,108,132	5.00
7.00	00700	OPERATION OF PLANT	24,368	24,368	528,549	0	3,840,052	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	22,856	0	249,756	8.00
9.00	00900	HOUSEKEEPING	2,806	2,806	338,446	0	590,642	9.00
10.00	01000	DIETARY	6,281	6,281	344,097	0	683,913	10.00
11.00	01100	CAFETERIA	0	0	309,237	0	543,082	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	452,208	0	567,716	13.00
15.00	01500	PHARMACY	1,939	1,939	402,036	0	1,410,999	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	3,063	855,124	0	1,361,355	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	20,373	2,629,762	0	3,984,682	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	5,595	929,967	0	1,331,436	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	6,406	1,072,976	0	1,555,507	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	42,950	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	16,260	1,799,948	0	963,848	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	19,886	1,004,635	0	3,425,421	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	264,436	0	425,630	55.01
57.00	05700	CT SCAN	0	0	109,537	0	651,078	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	1,706	280,052	0	806,962	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	1,438	157,117	0	363,210	59.00
60.00	06000	LABORATORY	9,274	9,274	1,831,259	0	5,057,286	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	135,539	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	8,976	977,848	0	1,487,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	376,539	0	677,546	67.00
67.01	06701	AUDIOLOGY	0	0	148,546	0	158,535	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	62,055	0	77,923	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	925	690,055	0	951,918	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,864,563	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,726,493	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	989,237	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	3,822	178,263	0	382,743	90.01
90.02	09002	CLINIC	6,145	6,145	0	0	96,080	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	35	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	1,089	0	191	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	17,804	90.12
90.13	09013	ALLERGY CLINIC	0	0	73,265	0	129,849	90.13
90.14	09014	WOUND CARE	3,504	3,504	208,968	0	434,461	90.14
91.00	09100	EMERGENCY	24,566	24,566	2,167,410	0	3,572,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,760	4,760	1,279,460	0	1,813,699	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	191,275	191,275	24,390,684	-20,208,567	45,371,569	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	9,756	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41,648	41,648	14,686,187	0	23,241,434	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	332	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,816	1,816	0	0	28,394	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	20,544	20,544	28,635	0	456,979	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)	1,294,333	2,706,904	6,851,471		20,208,567	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:17 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	5.057826	10.577686	0.175205		0.292420	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			9,100		291,962	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000233		0.004225	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	183,813					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	238,431,572				8.00
9.00	00900	HOUSEKEEPING	2,806	0	139,073			9.00
10.00	01000	DIETARY	6,281	0	8,623	38,043		10.00
11.00	01100	CAFETERIA	0	0	2,875	0	982	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,300	0	19	13.00
15.00	01500	PHARMACY	1,939	0	2,625	0	38	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	0	5,750	0	77	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,373	13,385,201	43,681	20,616	259	30.00
31.00	03100	INTENSIVE CARE UNIT	5,595	3,258,671	11,600	5,808	21	31.00
40.00	04000	SUBPROVIDER - IPF	6,406	2,974,630	13,794	11,619	33	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,388,576	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,260	35,867,735	2,575	0	23	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	18,373,262	11,650	0	28	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	6,874,166	750	0	3	55.01
57.00	05700	CT SCAN	0	27,327,666	1,150	0	4	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	11,034,527	1,100	0	10	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,438	2,954,793	0	0	0	59.00
60.00	06000	LABORATORY	9,274	41,390,225	4,925	0	82	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	813,233	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,040,965	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	8,976	5,185,883	1,775	0	41	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,102,304	850	0	17	67.00
67.01	06701	AUDIOLOGY	0	754,679	625	0	18	67.01
68.00	06800	SPEECH PATHOLOGY	0	384,615	375	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	925	8,884,597	3,775	0	41	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,193,725	0	0	21	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,726,493	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,151,658	2,725	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	0	6,700	0	34	90.01
90.02	09002	CLINIC	6,145	0	9,850	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	124,890	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	552,704	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	73,658	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	1,244,326	0	0	0	90.13
90.14	09014	WOUND CARE	3,504	2,108,385	0	0	64	90.14
91.00	09100	EMERGENCY	24,566	25,100,080	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,760	5,159,925	0	0	130	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	144,725	238,431,572	139,073	38,043	982	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,648	0	0	0	0	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	1,816	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	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)	4,962,960	322,790	839,120	1,105,518	719,237	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.000049	0.001354	6.033666	29.059696	732.420570	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	397,353	1,060	52,513	118,010	3,453	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:17 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	2.161724	0.000004	0.377593	3.102016	3.516293	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	15.00	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	342,836				13.00
15.00	01500	PHARMACY	0	1,124,103			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	41,100		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	75,859	3,117	10,100		30.00
31.00	03100	INTENSIVE CARE UNIT	23,579	395	2,100		31.00
40.00	04000	SUBPROVIDER - IPF	38,649	99	2,500		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	59,665	20,137	3,625		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,905	9,700		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	1,348	1,050		55.01
57.00	05700	CT SCAN	0	2,099	1,200		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,318	650		58.00
59.00	05900	CARDIAC CATHETERIZATION	4,628	24	0		59.00
60.00	06000	LABORATORY	0	232	1,000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	24,538	6,233	1,950		66.00
67.00	06700	OCCUPATIONAL THERAPY	10,926	0	850		67.00
67.01	06701	AUDIOLOGY	5,288	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	28,756	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	20,696	73	1,875		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	5,272	0	4,200		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	49	0		90.05
90.07	09007	UROLOGY CLINIC	0	904	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	4,695	42	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	14	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	396	0		90.12
90.13	09013	ALLERGY CLINIC	3,353	1,100	0		90.13
90.14	09014	WOUND CARE	7,100	3,231	0		90.14
91.00	09100	EMERGENCY	56,996	71,985	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	8,975	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	341,244	154,432	40,800		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,461	969,671	300		192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0		194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	131	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)	755,488	1,919,626	1,933,233		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.203643	1.707696	47.037299		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:17 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
			13.00	15.00	16.00			
204.00		Cost to be allocated (per Wkst. B, Part II)	3,062	41,689	62,905			204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.008931	0.037086	1.530535			205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,417,988		7,417,988	0	7,417,988	30.00
31.00	03100	INTENSIVE CARE UNIT	2,281,816		2,281,816	0	2,281,816	31.00
40.00	04000	SUBPROVIDER - IPF	2,835,332		2,835,332	47,755	2,883,087	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	57,389		57,389	0	57,389	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,102,043		2,102,043	0	2,102,043	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,539,198		5,539,198	0	5,539,198	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	617,814		617,814	0	617,814	55.01
57.00	05700	CT SCAN	948,366		948,366	0	948,366	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,154,138		1,154,138	0	1,154,138	58.00
59.00	05900	CARDIAC CATHETERIZATION	522,486		522,486	0	522,486	59.00
60.00	06000	LABORATORY	6,979,736		6,979,736	0	6,979,736	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	176,274		176,274	0	176,274	63.00
64.00	06400	INTRAVENOUS THERAPY	2,763		2,763	0	2,763	64.00
66.00	06600	PHYSICAL THERAPY	2,368,617	0	2,368,617	0	2,368,617	66.00
67.00	06700	OCCUPATIONAL THERAPY	958,806	0	958,806	0	958,806	67.00
67.01	06701	AUDIOLOGY	234,524	0	234,524	0	234,524	67.01
68.00	06800	SPEECH PATHOLOGY	166,516	0	166,516	0	166,516	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,454,016		1,454,016	0	1,454,016	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,430,858		2,430,858	0	2,430,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,115,014		6,115,014	0	6,115,014	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,310,051		1,310,051	0	1,310,051	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	872,362		872,362	0	872,362	90.01
90.02	09002	CLINIC	349,523		349,523	0	349,523	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	45		45	0	45	90.04
90.05	09005	SURGERY CLINIC	84		84	0	84	90.05
90.07	09007	UROLOGY CLINIC	1,713		1,713	0	1,713	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	10,665		10,665	0	10,665	90.09
90.11	09011	NEUROLOGY CLINIC	772		772	0	772	90.11
90.12	09012	OPTHAMOLOGY CLINIC	23,786		23,786	0	23,786	90.12
90.13	09013	ALLERGY CLINIC	178,771		178,771	0	178,771	90.13
90.14	09014	WOUND CARE	727,008		727,008	0	727,008	90.14
91.00	09100	EMERGENCY	5,562,638		5,562,638	0	5,562,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,350,229		1,350,229		1,350,229	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,509,110		2,509,110	0	2,509,110	95.00
200.00		Subtotal (see instructions)	57,260,451	0	57,260,451	47,755	57,308,206	200.00
201.00		Less Observation Beds	1,350,229		1,350,229		1,350,229	201.00
202.00		Total (see instructions)	55,910,222	0	55,910,222	47,755	55,957,977	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,128,564		11,128,564			30.00
31.00	03100	INTENSIVE CARE UNIT	3,258,671		3,258,671			31.00
40.00	04000	SUBPROVIDER - IPF	2,974,630		2,974,630			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,388,576		1,388,576			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,187,842	29,679,893	35,867,735	0.058605	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,206,080	17,167,182	18,373,262	0.301481	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	424,905	6,449,261	6,874,166	0.089875	0.000000	55.01
57.00	05700	CT SCAN	3,318,533	24,009,133	27,327,666	0.034704	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	750,304	10,284,223	11,034,527	0.104593	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,377,164	1,577,629	2,954,793	0.176827	0.000000	59.00
60.00	06000	LABORATORY	7,486,740	33,903,485	41,390,225	0.168632	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	402,433	410,800	813,233	0.216757	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	956,893	1,084,072	2,040,965	0.001354	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	605,203	4,580,680	5,185,883	0.456743	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	313,319	788,985	1,102,304	0.869820	0.000000	67.00
67.01	06701	AUDIOLOGY	431	754,248	754,679	0.310760	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	37,545	347,070	384,615	0.432942	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	3,632,091	5,252,506	8,884,597	0.163656	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,905,517	2,288,208	4,193,725	0.579642	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,445,312	2,281,181	4,726,493	1.293774	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,722,414	5,429,244	11,151,658	0.117476	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	124,890	124,890	0.013716	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	552,704	552,704	0.001397	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	73,658	73,658	0.322925	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	1,244,326	1,244,326	0.143669	0.000000	90.13
90.14	09014	WOUND CARE	5,982	2,102,403	2,108,385	0.344817	0.000000	90.14
91.00	09100	EMERGENCY	2,848,837	22,251,243	25,100,080	0.221618	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,256,637	2,256,637	0.598337	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,769	5,150,156	5,159,925	0.486269	0.000000	95.00
200.00		Subtotal (see instructions)	58,387,755	180,043,817	238,431,572			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	58,387,755	180,043,817	238,431,572			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio 11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.058605		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.301481		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.089875		55.01
57.00	05700	CT SCAN	0.034704		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.104593		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176827		59.00
60.00	06000	LABORATORY	0.168632		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.216757		63.00
64.00	06400	INTRAVENOUS THERAPY	0.001354		64.00
66.00	06600	PHYSICAL THERAPY	0.456743		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.869820		67.00
67.01	06701	AUDIOLOGY	0.310760		67.01
68.00	06800	SPEECH PATHOLOGY	0.432942		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.163656		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.579642		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.293774		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117476		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.013716		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.001397		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.322925		90.12
90.13	09013	ALLERGY CLINIC	0.143669		90.13
90.14	09014	WOUND CARE	0.344817		90.14
91.00	09100	EMERGENCY	0.221618		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.598337		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.486269		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:17 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	7,417,988		7,417,988	0	7,417,988	30.00
31.00	03100	INTENSIVE CARE UNIT	2,281,816		2,281,816	0	2,281,816	31.00
40.00	04000	SUBPROVIDER - IPF	2,835,332		2,835,332	47,755	2,883,087	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	57,389		57,389	0	57,389	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,102,043		2,102,043	0	2,102,043	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,539,198		5,539,198	0	5,539,198	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
55.01	05501	ULTRA SOUND	617,814		617,814	0	617,814	55.01
57.00	05700	CT SCAN	948,366		948,366	0	948,366	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,154,138		1,154,138	0	1,154,138	58.00
59.00	05900	CARDIAC CATHETERIZATION	522,486		522,486	0	522,486	59.00
60.00	06000	LABORATORY	6,979,736		6,979,736	0	6,979,736	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	176,274		176,274	0	176,274	63.00
64.00	06400	INTRAVENOUS THERAPY	2,763		2,763	0	2,763	64.00
66.00	06600	PHYSICAL THERAPY	2,368,617	0	2,368,617	0	2,368,617	66.00
67.00	06700	OCCUPATIONAL THERAPY	958,806	0	958,806	0	958,806	67.00
67.01	06701	AUDIOLOGY	234,524	0	234,524	0	234,524	67.01
68.00	06800	SPEECH PATHOLOGY	166,516	0	166,516	0	166,516	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	06901	CARDIOLOGY	1,454,016		1,454,016	0	1,454,016	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,430,858		2,430,858	0	2,430,858	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,115,014		6,115,014	0	6,115,014	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,310,051		1,310,051	0	1,310,051	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	872,362		872,362	0	872,362	90.01
90.02	09002	CLINIC	349,523		349,523	0	349,523	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	90.03
90.04	09004	ENT CLINIC	45		45	0	45	90.04
90.05	09005	SURGERY CLINIC	84		84	0	84	90.05
90.07	09007	UROLOGY CLINIC	1,713		1,713	0	1,713	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	10,665		10,665	0	10,665	90.09
90.11	09011	NEUROLOGY CLINIC	772		772	0	772	90.11
90.12	09012	OPTHAMOLOGY CLINIC	23,786		23,786	0	23,786	90.12
90.13	09013	ALLERGY CLINIC	178,771		178,771	0	178,771	90.13
90.14	09014	WOUND CARE	727,008		727,008	0	727,008	90.14
91.00	09100	EMERGENCY	5,562,638		5,562,638	0	5,562,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,350,229		1,350,229		1,350,229	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,509,110		2,509,110	0	2,509,110	95.00
200.00		Subtotal (see instructions)	57,260,451	0	57,260,451	47,755	57,308,206	200.00
201.00		Less Observation Beds	1,350,229		1,350,229		1,350,229	201.00
202.00		Total (see instructions)	55,910,222	0	55,910,222	47,755	55,957,977	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:17 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	11,128,564		11,128,564			30.00
31.00	03100	INTENSIVE CARE UNIT	3,258,671		3,258,671			31.00
40.00	04000	SUBPROVIDER - IPF	2,974,630		2,974,630			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,388,576		1,388,576			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,187,842	29,679,893	35,867,735	0.058605	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,206,080	17,167,182	18,373,262	0.301481	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	424,905	6,449,261	6,874,166	0.089875	0.000000	55.01
57.00	05700	CT SCAN	3,318,533	24,009,133	27,327,666	0.034704	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	750,304	10,284,223	11,034,527	0.104593	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,377,164	1,577,629	2,954,793	0.176827	0.000000	59.00
60.00	06000	LABORATORY	7,486,740	33,903,485	41,390,225	0.168632	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	402,433	410,800	813,233	0.216757	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	956,893	1,084,072	2,040,965	0.001354	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	605,203	4,580,680	5,185,883	0.456743	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	313,319	788,985	1,102,304	0.869820	0.000000	67.00
67.01	06701	AUDIOLOGY	431	754,248	754,679	0.310760	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	37,545	347,070	384,615	0.432942	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	3,632,091	5,252,506	8,884,597	0.163656	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,905,517	2,288,208	4,193,725	0.579642	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,445,312	2,281,181	4,726,493	1.293774	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,722,414	5,429,244	11,151,658	0.117476	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	0	124,890	124,890	0.013716	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	0	552,704	552,704	0.001397	0.000000	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	73,658	73,658	0.322925	0.000000	90.12
90.13	09013	ALLERGY CLINIC	0	1,244,326	1,244,326	0.143669	0.000000	90.13
90.14	09014	WOUND CARE	5,982	2,102,403	2,108,385	0.344817	0.000000	90.14
91.00	09100	EMERGENCY	2,848,837	22,251,243	25,100,080	0.221618	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,256,637	2,256,637	0.598337	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,769	5,150,156	5,159,925	0.486269	0.000000	95.00
200.00		Subtotal (see instructions)	58,387,755	180,043,817	238,431,572			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	58,387,755	180,043,817	238,431,572			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:17 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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501	ULTRA SOUND	0.000000		55.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701	AUDIOLOGY	0.000000		67.01
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901	CARDIOLOGY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		90.01
90.02	09002	CLINIC	0.000000		90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000		90.03
90.04	09004	ENT CLINIC	0.000000		90.04
90.05	09005	SURGERY CLINIC	0.000000		90.05
90.07	09007	UROLOGY CLINIC	0.000000		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000		90.09
90.11	09011	NEUROLOGY CLINIC	0.000000		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.000000		90.12
90.13	09013	ALLERGY CLINIC	0.000000		90.13
90.14	09014	WOUND CARE	0.000000		90.14
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	477,692	0	477,692	6,296	75.87	30.00
31.00	INTENSIVE CARE UNIT	131,342		131,342	1,487	88.33	31.00
40.00	SUBPROVIDER - IPF	166,385	0	166,385	2,987	55.70	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	187		187	997	0.19	43.00
200.00	Total (lines 30-199)	775,606		775,606	11,767		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,255	171,087	30.00
31.00	INTENSIVE CARE UNIT	763	67,396	31.00
40.00	SUBPROVIDER - IPF	2,474	137,802	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	5,492	376,285	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	301,898	35,867,735	0.008417	2,757,997	23,214	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,109	18,373,262	0.021124	946,312	19,990	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	3,838	6,874,166	0.000558	73,933	41	55.01
57.00	05700	CT SCAN	5,249	27,327,666	0.000192	1,584,674	304	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	35,449	11,034,527	0.003213	730,314	2,346	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,219	2,954,793	0.009212	425,138	3,916	59.00
60.00	06000	LABORATORY	190,806	41,390,225	0.004610	4,009,741	18,485	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	576	813,233	0.000708	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8	2,040,965	0.000004	167,692	1	64.00
66.00	06600	PHYSICAL THERAPY	170,529	5,185,883	0.032883	349,669	11,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,735	1,102,304	0.004296	201,067	864	67.00
67.01	06701	AUDIOLOGY	1,054	754,679	0.001397	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,620	384,615	0.004212	29,120	123	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	25,308	8,884,597	0.002849	2,526,294	7,197	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,969	4,193,725	0.001900	8,854	17	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,988	4,726,493	0.004229	1,158,965	4,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,254	11,151,658	0.000471	3,219,543	1,516	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	78,805	0	0.000000	0	0	90.01
90.02	09002	CLINIC	113,489	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	2	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	34	124,890	0.000272	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	45	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	3	552,704	0.000005	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	90	73,658	0.001222	0	0	90.12
90.13	09013	ALLERGY CLINIC	642	1,244,326	0.000516	0	0	90.13
90.14	09014	WOUND CARE	64,663	2,108,385	0.030669	495	15	90.14
91.00	09100	EMERGENCY	456,084	25,100,080	0.018171	1,168,508	21,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	86,949	2,256,637	0.038530	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,990,415	214,521,206		19,358,316	115,661	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,296	0.00	2,255	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,487	0.00	763	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,987	0.00	2,474	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	997	0.00	0	0		43.00
200.00		Total (lines 30-199)	11,767		5,492	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,867,735	0.000000	0.000000	2,757,997	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,373,262	0.000000	0.000000	946,312	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0	6,874,166	0.000000	0.000000	73,933	55.01
57.00	05700	CT SCAN	0	27,327,666	0.000000	0.000000	1,584,674	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	11,034,527	0.000000	0.000000	730,314	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,954,793	0.000000	0.000000	425,138	59.00
60.00	06000	LABORATORY	0	41,390,225	0.000000	0.000000	4,009,741	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	813,233	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,040,965	0.000000	0.000000	167,692	64.00
66.00	06600	PHYSICAL THERAPY	0	5,185,883	0.000000	0.000000	349,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,102,304	0.000000	0.000000	201,067	67.00
67.01	06701	AUDIOLOGY	0	754,679	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	384,615	0.000000	0.000000	29,120	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0	8,884,597	0.000000	0.000000	2,526,294	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,193,725	0.000000	0.000000	8,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,726,493	0.000000	0.000000	1,158,965	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,151,658	0.000000	0.000000	3,219,543	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0	124,890	0.000000	0.000000	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	552,704	0.000000	0.000000	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	73,658	0.000000	0.000000	0	90.12
90.13	09013	ALLERGY CLINIC	0	1,244,326	0.000000	0.000000	0	90.13
90.14	09014	WOUND CARE	0	2,108,385	0.000000	0.000000	495	90.14
91.00	09100	EMERGENCY	0	25,100,080	0.000000	0.000000	1,168,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,256,637	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	214,521,206			19,358,316	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	8,804,862	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,327,903	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	1,352,844	0		55.01
57.00	05700	CT SCAN	0	5,549,871	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,392,436	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	554,932	0		59.00
60.00	06000	LABORATORY	0	3,460,410	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	131,009	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	258,917	0		64.00
66.00	06600	PHYSICAL THERAPY	0	2,034	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6	0		67.00
67.01	06701	AUDIOLOGY	0	107,837	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	0	2,157,653	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	426,143	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	38,943	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,262,872	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	171,553	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	722	0		90.12
90.13	09013	ALLERGY CLINIC	0	51,949	0		90.13
90.14	09014	WOUND CARE	0	175,979	0		90.14
91.00	09100	EMERGENCY	0	3,244,316	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	968,248	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	39,441,439	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.058605	8,804,862	0	0	516,009	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.301481	5,327,903	0	0	1,606,262	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.089875	1,352,844	0	0	121,587	55.01
57.00	05700	CT SCAN	0.034704	5,549,871	0	0	192,603	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.104593	3,392,436	0	0	354,825	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176827	554,932	0	0	98,127	59.00
60.00	06000	LABORATORY	0.168632	3,460,410	0	0	583,536	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.216757	131,009	0	0	28,397	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001354	258,917	0	0	351	64.00
66.00	06600	PHYSICAL THERAPY	0.456743	2,034	0	0	929	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.869820	6	0	0	5	67.00
67.01	06701	AUDIOLOGY	0.310760	107,837	0	0	33,511	67.01
68.00	06800	SPEECH PATHOLOGY	0.432942	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.163656	2,157,653	0	0	353,113	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.579642	426,143	0	0	247,010	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.293774	38,943	0	0	50,383	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117476	3,262,872	0	9,684	383,309	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.013716	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001397	171,553	0	0	240	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.322925	722	0	0	233	90.12
90.13	09013	ALLERGY CLINIC	0.143669	51,949	0	0	7,463	90.13
90.14	09014	WOUND CARE	0.344817	175,979	0	0	60,681	90.14
91.00	09100	EMERGENCY	0.221618	3,244,316	0	0	718,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.598337	968,248	0	0	579,339	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.486269		0			95.00
200.00		Subtotal (see instructions)		39,441,439	0	9,684	5,936,912	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		39,441,439	0	9,684	5,936,912	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	55.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,138	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	90.03
90.04	09004	ENT CLINIC	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	90.13
90.14	09014	WOUND CARE	0	0	90.14
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	1,138	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,138	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	301,898	35,867,735	0.008417	131	1	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	388,109	18,373,262	0.021124	95,859	2,025	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	3,838	6,874,166	0.000558	0	0	55.01
57.00	05700	CT SCAN	5,249	27,327,666	0.000192	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	35,449	11,034,527	0.003213	15,880	51	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,219	2,954,793	0.009212	22	0	59.00
60.00	06000	LABORATORY	190,806	41,390,225	0.004610	466,390	2,150	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	576	813,233	0.000708	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8	2,040,965	0.000004	5,078	0	64.00
66.00	06600	PHYSICAL THERAPY	170,529	5,185,883	0.032883	27,459	903	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,735	1,102,304	0.004296	11,708	50	67.00
67.01	06701	AUDIOLOGY	1,054	754,679	0.001397	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	1,620	384,615	0.004212	1,235	5	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	25,308	8,884,597	0.002849	61,395	175	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,969	4,193,725	0.001900	108	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	19,988	4,726,493	0.004229	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,254	11,151,658	0.000471	551,351	260	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	78,805	0	0.000000	0	0	90.01
90.02	09002	CLINIC	113,489	0	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	2	0	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	34	124,890	0.000272	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	45	0	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	3	552,704	0.000005	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	90	73,658	0.001222	0	0	90.12
90.13	09013	ALLERGY CLINIC	642	1,244,326	0.000516	0	0	90.13
90.14	09014	WOUND CARE	64,663	2,108,385	0.030669	15	0	90.14
91.00	09100	EMERGENCY	456,084	25,100,080	0.018171	13,245	241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,256,637	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,903,466	214,521,206		1,249,876	5,861	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 Component CCN: 15S104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,867,735	0.000000	0.000000	131	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,373,262	0.000000	0.000000	95,859	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0	6,874,166	0.000000	0.000000	0	55.01
57.00	05700	CT SCAN	0	27,327,666	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	11,034,527	0.000000	0.000000	15,880	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,954,793	0.000000	0.000000	22	59.00
60.00	06000	LABORATORY	0	41,390,225	0.000000	0.000000	466,390	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	813,233	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,040,965	0.000000	0.000000	5,078	64.00
66.00	06600	PHYSICAL THERAPY	0	5,185,883	0.000000	0.000000	27,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,102,304	0.000000	0.000000	11,708	67.00
67.01	06701	AUDIOLOGY	0	754,679	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	384,615	0.000000	0.000000	1,235	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0	8,884,597	0.000000	0.000000	61,395	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,193,725	0.000000	0.000000	108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,726,493	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,151,658	0.000000	0.000000	551,351	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0	124,890	0.000000	0.000000	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	552,704	0.000000	0.000000	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	73,658	0.000000	0.000000	0	90.12
90.13	09013	ALLERGY CLINIC	0	1,244,326	0.000000	0.000000	0	90.13
90.14	09014	WOUND CARE	0	2,108,385	0.000000	0.000000	15	90.14
91.00	09100	EMERGENCY	0	25,100,080	0.000000	0.000000	13,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,256,637	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	214,521,206			1,249,876	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501	ULTRA SOUND	0	0	0		55.01
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	06701	AUDIOLOGY	0	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	CARDIOLOGY	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	327	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		90.01
90.02	09002	CLINIC	0	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0		90.03
90.04	09004	ENT CLINIC	0	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0	0		90.13
90.14	09014	WOUND CARE	0	0	0		90.14
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	327	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.058605	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.301481	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0.089875	0	0	0	0	55.01
57.00	05700	CT SCAN	0.034704	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.104593	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176827	0	0	0	0	59.00
60.00	06000	LABORATORY	0.168632	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.216757	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001354	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.456743	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.869820	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0.310760	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.432942	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0.163656	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.579642	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.293774	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117476	327	0	815	38	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.013716	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001397	0	0	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.322925	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.143669	0	0	0	0	90.13
90.14	09014	WOUND CARE	0.344817	0	0	0	0	90.14
91.00	09100	EMERGENCY	0.221618	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.598337	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.486269		0			95.00
200.00		Subtotal (see instructions)		327	0	815	38	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		327	0	815	38	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01	05501	ULTRA SOUND	0	0		55.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
67.01	06701	AUDIOLOGY	0	0		67.01
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIOLOGY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	96		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02	09002	CLINIC	0	0		90.02
90.03	09003	DERMATOLOGY CLINIC	0	0		90.03
90.04	09004	ENT CLINIC	0	0		90.04
90.05	09005	SURGERY CLINIC	0	0		90.05
90.07	09007	UROLOGY CLINIC	0	0		90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0		90.09
90.11	09011	NEUROLOGY CLINIC	0	0		90.11
90.12	09012	OPTHAMOLOGY CLINIC	0	0		90.12
90.13	09013	ALLERGY CLINIC	0	0		90.13
90.14	09014	WOUND CARE	0	0		90.14
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	96		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	96		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,296	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,296	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,150	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,255	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,417,988	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,417,988	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)	7,417,988	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)	1,178.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,656,864	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,656,864	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,281,816	1,487	1,534.51	763	1,170,831	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)	4,239,101	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,066,796	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)	238,483	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	115,661	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	354,144	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,712,652	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,146	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,178.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,350,229	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	477,692	7,417,988	0.064396	1,350,229	86,949	90.00
91.00	Nursing School cost	0	7,417,988	0.000000	1,350,229	0	91.00
92.00	Allied health cost	0	7,417,988	0.000000	1,350,229	0	92.00
93.00	All other Medical Education	0	7,417,988	0.000000	1,350,229	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/28/2015 2:17 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,987	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,987	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,987	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,474	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,883,087	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,883,087	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,883,087	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)	965.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,387,930	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,387,930	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 15S104 | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	210,311	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,598,241	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)	137,802	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,861	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	143,663	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,454,578	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 15S104 | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	166,385	2,883,087	0.057711	0	0	90.00
91.00	Nursing School cost	0	2,883,087	0.000000	0	0	91.00
92.00	Allied health cost	0	2,883,087	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,883,087	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150104	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/28/2015 2:17 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)	6,296	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,296	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,150	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	417	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)	997	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,417,988	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,417,988	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)	7,417,988	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)	1,178.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	491,314	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)	491,314	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:17 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)	57,389	997	57.56	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,281,816	1,487	1,534.51	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	223,206	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	714,520	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,146	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,178.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,350,229	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:17 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	477,692	7,417,988	0.064396	1,350,229	86,949	90.00
91.00	Nursing School cost	0	7,417,988	0.000000	1,350,229	0	91.00
92.00	Allied health cost	0	7,417,988	0.000000	1,350,229	0	92.00
93.00	All other Medical Education	0	7,417,988	0.000000	1,350,229	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,067,532		30.00
31.00	03100	INTENSIVE CARE UNIT		1,489,614		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.058605	2,757,997	161,632	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.301481	946,312	285,295	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.089875	73,933	6,645	55.01
57.00	05700	CT SCAN	0.034704	1,584,674	54,995	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.104593	730,314	76,386	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176827	425,138	75,176	59.00
60.00	06000	LABORATORY	0.168632	4,009,741	676,171	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.216757	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001354	167,692	227	64.00
66.00	06600	PHYSICAL THERAPY	0.456743	349,669	159,709	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.869820	201,067	174,892	67.00
67.01	06701	AUDIOLOGY	0.310760	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.432942	29,120	12,607	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.163656	2,526,294	413,443	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.579642	8,854	5,132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.293774	1,158,965	1,499,439	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117476	3,219,543	378,219	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.013716	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001397	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.322925	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.143669	0	0	90.13
90.14	09014	WOUND CARE	0.344817	495	171	90.14
91.00	09100	EMERGENCY	0.221618	1,168,508	258,962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.598337	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		19,358,316	4,239,101	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)		19,358,316		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150104 | Component CCN: 15S104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,460,185		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.058605	131	8	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.301481	95,859	28,900	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.089875	0	0	55.01
57.00	05700	CT SCAN	0.034704	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.104593	15,880	1,661	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176827	22	4	59.00
60.00	06000	LABORATORY	0.168632	466,390	78,648	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.216757	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001354	5,078	7	64.00
66.00	06600	PHYSICAL THERAPY	0.456743	27,459	12,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.869820	11,708	10,184	67.00
67.01	06701	AUDIOLOGY	0.310760	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.432942	1,235	535	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.163656	61,395	10,048	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.579642	108	63	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.293774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117476	551,351	64,771	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.013716	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001397	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.322925	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.143669	0	0	90.13
90.14	09014	WOUND CARE	0.344817	15	5	90.14
91.00	09100	EMERGENCY	0.221618	13,245	2,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.598337	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,249,876	210,311	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)		1,249,876		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 2:17 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		1,283,768		30.00
31.00	03100	INTENSIVE CARE UNIT		73,725		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		290,595		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.058605	172,922	10,134	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.301481	41,823	12,609	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501	ULTRA SOUND	0.089875	15,147	1,361	55.01
57.00	05700	CT SCAN	0.034704	92,374	3,206	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.104593	4,110	430	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.176827	46,274	8,182	59.00
60.00	06000	LABORATORY	0.168632	263,205	44,385	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.216757	23,164	5,021	63.00
64.00	06400	INTRAVENOUS THERAPY	0.001354	50,731	69	64.00
66.00	06600	PHYSICAL THERAPY	0.456743	8,859	4,046	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.869820	4,859	4,226	67.00
67.01	06701	AUDIOLOGY	0.310760	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0.432942	640	277	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901	CARDIOLOGY	0.163656	85,856	14,051	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.579642	122,185	70,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.293774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.117476	209,258	24,583	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002	CLINIC	0.000000	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004	ENT CLINIC	0.000000	0	0	90.04
90.05	09005	SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007	UROLOGY CLINIC	0.013716	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0.001397	0	0	90.11
90.12	09012	OPTHAMOLOGY CLINIC	0.322925	0	0	90.12
90.13	09013	ALLERGY CLINIC	0.143669	0	0	90.13
90.14	09014	WOUND CARE	0.344817	19	7	90.14
91.00	09100	EMERGENCY	0.221618	89,320	19,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.598337	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,230,746	223,206	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)		1,230,746		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		4,020,041		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,340,014		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		19,372		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		64.86		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.71		30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.48		31.00
32.00	Sum of lines 30 and 31		28.19		32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00		33.00
34.00	Disproportionate share adjustment (see instructions)		160,802		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000059567	0.000056846	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		538,863	434,737	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		403,040	109,578	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		512,618		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		6,052,847		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		6,052,847		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		433,555		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,486,402		59.00
60.00	Primary payer payments		3,538		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,482,864		61.00
62.00	Deductibles billed to program beneficiaries		790,112		62.00
63.00	Coinsurance billed to program beneficiaries		3,040		63.00
64.00	Allowable bad debts (see instructions)		36,409		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		23,666		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		21,366		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,713,378		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	PER PS&R		-1,189		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		6,747		70.93
70.94	HRR adjustment amount (see instructions)		-1,600		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2014	401,135		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2015	169,177		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		21,037		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,266,611		71.00
71.01	Sequestration adjustment (see instructions)		125,332		71.01
72.00	Interim payments		6,076,310		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		64,969		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,885,574		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,020,041	0	4,020,041	0	4,020,041	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,340,014	0	0	1,340,014	1,340,014	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	19,372	0	14,529	4,843	19,372	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	160,802	0	120,601	40,201	160,802	11.00
11.01	Uncompensated care payments	36.00	512,618	0	403,040	109,578	512,618	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,052,847	0	4,558,211	1,494,636	6,052,847	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,052,847	0	4,558,211	1,494,636	6,052,847	15.00
16.00	Payment for inpatient program capital	50.00	433,555	0	325,166	108,389	433,555	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	4,883,377	1,603,025	6,486,402	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	428,519	0	321,389	107,130	428,519	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,036	0	3,777	1,259	5,036	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	433,555	0	325,166	108,389	433,555	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.082143	0.105536		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			401,135		401,135	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				169,177	169,177	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,020,041	4,020,041		4,020,041	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,340,014		1,340,014	1,340,014	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	19,372	14,529	4,843	19,372	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	160,802	120,601	40,201	160,802	11.00
11.01	Uncompensated care payments	36.00	512,618	403,040	109,578	512,618	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,052,847	4,558,211	1,494,636	6,052,847	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,052,847	4,558,211	1,494,636	6,052,847	15.00
16.00	Payment for inpatient program capital	50.00	433,555	0	433,555	433,555	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,558,211	1,928,191	6,486,402	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	428,519	0	428,519	428,519	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	5,036	0	5,036	5,036	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	433,555	0	433,555	433,555	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	401,135	401,135		401,135	28.00
29.00	Low volume adjustment on or after October 1	70.97	169,177		169,177	169,177	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	6,747	0	6,747	6,747	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-1,600	-1,197	-403	-1,600	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	21,037	21,037	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150104	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 2:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,138	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,936,912	2.00
3.00	PPS payments	6,908,507	3.00
4.00	Outlier payment (see instructions)	3,152	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)	1,138	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	9,684	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)	9,684	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)	9,684	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	8,546	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)	1,138	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)	6,911,659	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,548,192	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)	5,364,605	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)	5,364,605	30.00
31.00	Primary payer payments	1,089	31.00
32.00	Subtotal (line 30 minus line 31)	5,363,516	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)	121,656	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	79,076	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	108,044	36.00
37.00	Subtotal (see instructions)	5,442,592	37.00
38.00	MSP-LCC reconciliation amount from PS&R	1,089	38.00
39.00	PER PS&R	82	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)	5,441,585	40.00
40.01	Sequestration adjustment (see instructions)	108,832	40.01
41.00	Interim payments	5,255,854	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	76,899	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 2:17 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	96	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	38	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)	96	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	815	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)	815	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)	815	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	719	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)	96	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)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	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)	96	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)	96	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	96	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	96	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)	96	40.00
40.01	Sequestration adjustment (see instructions)	2	40.01
41.00	Interim payments	275	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-181	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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2015 2:17 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,076,310		5,255,854	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)		6,076,310		5,255,854	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		64,969		76,899	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,141,279		5,332,753	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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2015 2:17 pm

Component CCN: 15S104 | Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,083,166		275	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)		2,083,166		275	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		181	6.02
7.00	Total Medicare program liability (see instructions)		2,083,166		94	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: 150104	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/28/2015 2:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,247	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,018	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	707	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	6,637	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	238,431,572	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	5,005,783	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)	636,249	8.00
9.00	Sequestration adjustment amount (see instructions)	12,725	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	623,524	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	569,745	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)	53,779	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/28/2015 2:17 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,262,419	1.00
2.00	Net IPF PPS Outlier Payments	47,997	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	8.183562	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,310,416	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,310,416	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,310,416	18.00
19.00	Deductibles	168,928	19.00
20.00	Subtotal (line 18 minus line 19)	2,141,488	20.00
21.00	Coinsurance	15,808	21.00
22.00	Subtotal (line 20 minus line 21)	2,125,680	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,125,680	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,125,680	31.00
31.01	Sequestration adjustment (see instructions)	42,514	31.01
32.00	Interim payments	2,083,166	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	47,997	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150104	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2015 2:17 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	714,520		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)	714,520	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)	714,520	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,230,746	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)	1,230,746	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)	1,230,746	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	516,226	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)	714,520	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)	714,520	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)	714,520	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)	714,520	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	714,520	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)	714,520	0	40.00
41.00	Interim payments	1,209,978	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-495,458	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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/28/2015 2:17 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	20,955,846	0	0	0	1.00
2.00	Temporary investments	18,585,331	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,965,401	0	0	0	4.00
5.00	Other receivable	2,767,779	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,483,173	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,210,000	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)	61,967,530	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	12,992,304	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,017,431	0	0	0	15.00
16.00	Accumulated depreciation	0	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	124,844,782	0	0	0	23.00
24.00	Accumulated depreciation	-55,128,404	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)	84,726,113	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	14,758,114	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,758,114	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	161,451,757	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,425,892	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,427,690	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	51,943	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	6,230,726	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,136,251	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	450,175	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	62,259,612	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	62,709,787	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	81,846,038	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	79,605,719				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)	79,605,719	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	161,451,757	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/28/2015 2:17 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		81,706,879		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,101,160				2.00
3.00	Total (sum of line 1 and line 2)		79,605,719		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)		79,605,719		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)		79,605,719		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: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/28/2015 2:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,114,386		15,114,386	1.00
2.00	SUBPROVIDER - IPF	2,974,630		2,974,630	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	18,089,016		18,089,016	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,276,314		3,276,314	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)	3,276,314		3,276,314	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	21,365,330		21,365,330	17.00
18.00	Ancillary services	36,755,635	153,638,292	190,393,927	18.00
19.00	Outpatient services	2,883,014	31,874,625	34,757,639	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYS PRACTICE	2,121	32,169,852	32,171,973	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	61,006,100	217,682,769	278,688,869	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		97,566,349		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)		97,566,349		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150104 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/28/2015 2:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	278,688,869	1.00
2.00	Less contractual allowances and discounts on patients' accounts	176,387,051	2.00
3.00	Net patient revenues (line 1 minus line 2)	102,301,818	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	97,566,349	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,735,469	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 OPERATING/NONOPERATING	3,999,667	24.00
25.00	Total other income (sum of lines 6-24)	3,999,667	25.00
26.00	Total (line 5 plus line 25)	8,735,136	26.00
27.00	ADDTL EXP/TRANSFERS	10,836,296	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	10,836,296	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,101,160	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150104	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/28/2015 2:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	428,519	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,036	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	18.68	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	433,555	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00