

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: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/27/2015 6:08 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/27/2015 Time: 6:08 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 COMMUNITY HOSPITAL OF INDIANA, INC. (150169) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-234,988	-122,055	4,373	0	1.00
2.00 Subprovider - IPF	0	8,628	122		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-226,360	-121,933	4,373	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 6:07 pm			
1.00			2.00		3.00			4.00				
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 7150 CLEARVISTA PARKWAY				PO Box:							1.00
2.00	City: INDIANAPOLIS				State: IN		Zip Code: 46256		County: MARI ON			2.00
Component Name												
CCN Number												
CBSA Number												
Provider Type												
Date Certified												
Payment System (P, T, O, or N)												
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 6:07 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)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N		N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N		N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N		N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				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.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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)		1.76	1.76		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>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.</u>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	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: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 6:07 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)	FAMILY PRACTICE	1350	0.00	1.89	0.000000 67.00	
				1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS 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)			N	0		76.00
				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N			81.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 6:07 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	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	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	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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,026,885	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
DO NOT USE THIS LINE					
119.00	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		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: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 6:07 pm	
		1.00	2.00				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y			140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: COMMUNITY HEALTH NETWORK	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 08101		141.00	
142.00	Street: 1500 NORTH RITTER AVENUE	PO Box:				142.00	
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46219-3095		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y		145.00	
				1.00			
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	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						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	
						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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 6:07 pm	
			Beginning 1.00	Ending 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)		04/01/2014	06/30/2014	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: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 6:07 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.	Y			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.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	Y			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	
		Y/N	Date	Y/N	
		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	04/29/2014	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: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 6:07 pm	
	Description	Part A		Part B			
		Y/N	Date	Y/N			
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N					21.00
						1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions						22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.						23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions						24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.						25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.						26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.						27.00
Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.						28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions						29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.						30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.						31.00
Purchased Services							
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.						32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.						33.00
Provider-Based Physicians							
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.						34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.						35.00
						Y/N	Date
						1.00	2.00
Home Office Costs							
36.00	Were home office costs claimed on the cost report?						36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.						37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.						38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.						39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.						40.00
						1.00	2.00
Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RONALD		HELMS			41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH NETWORK					42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-5501		RHELMS@COMMUNITY.COM			43.00

		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)	04/29/2014	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.	REIMBURSEMENT 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: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2015 6:07 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	218	79,539	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)		218	79,539	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	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 NEONATAL INTENSIVE CARE UNIT	35.00	43	15,695	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		285	103,994	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,570		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		303				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: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-3
Part I
Date/Time Prepared:
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	18,408	2,566	51,749			1.00
2.00 HMO and other (see instructions)	6,432	15,367				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)	18,408	2,566	51,749			7.00
8.00 INTENSIVE CARE UNIT	2,140	0	5,161			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 NEONATAL INTENSIVE CARE UNIT	0	0	11,463			12.00
13.00 NURSERY		1,485	7,861			13.00
14.00 Total (see instructions)	20,548	4,051	76,234	1.89	1,303.93	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,633	0	3,120	0.00	16.27	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	791			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)				1.89	1,320.20	27.00
28.00 Observation Bed Days		684	4,994			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			2,017			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	454	1,300			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: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2015 6:07 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	4,327	3,241	13,677	1.00
2.00 HMO and other (see instructions)			1,300	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 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	4,327	3,241	13,677	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	276	0	348	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet S-3 Part II Date/Time Prepared: 5/27/2015 6:07 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	89,450,322	-389,795	89,060,527	2,746,025.00	32.43	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)		2,503,714	225,149	2,728,863	58,109.00	46.96	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		325,100	0	325,100	5,129.00	63.38	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		114,833	0	114,833	1,283.00	89.50	13.00
14.00	Home office salaries & wage-related costs		11,146,515	0	11,146,515	191,717.00	58.14	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)		28,413,615	0	28,413,615			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		677,742	0	677,742			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	327,784	0	327,784	10,009.00	32.75	26.00
27.00	Administrative & General	5.00	11,205,703	-26,559	11,179,144	102,628.00	108.93	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	2,378,951	-10,574	2,368,377	113,229.00	20.92	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,930,340	-25,472	1,904,868	142,560.00	13.36	32.00
33.00	Housekeeping under contract (see instructions)		446,980	0	446,980	9,911.00	45.10	33.00
34.00	Dietary	10.00	2,262,879	-1,211,937	1,050,942	52,811.00	19.90	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,202,971	1,202,971	86,671.00	13.88	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	511,034	-1,828	509,206	29,654.00	17.17	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	3,259,413	-223,836	3,035,577	77,264.00	39.29	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-3
Part II
Date/Time Prepared:
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	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	16.00 460,823	-4,860	455,963	13,288.00	34.31	41.00
42.00	Social Service	17.00 1,806,039	-2,010	1,804,029	52,380.00	34.44	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-3
Part III
Date/Time Prepared:
5/27/2015 6:07 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation 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)	89,897,302	-389,795	89,507,507	2,755,936.00	32.48	1.00
2.00	Excluded area salaries (see instructions)	2,503,714	225,149	2,728,863	58,109.00	46.96	2.00
3.00	Subtotal salaries (line 1 minus line 2)	87,393,588	-614,944	86,778,644	2,697,827.00	32.17	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,586,448	0	11,586,448	198,129.00	58.48	4.00
5.00	Subtotal wage-related costs (see inst.)	28,413,615	0	28,413,615	0.00	32.74	5.00
6.00	Total (sum of lines 3 thru 5)	127,393,651	-614,944	126,778,707	2,895,956.00	43.78	6.00
7.00	Total overhead cost (see instructions)	24,589,946	-304,105	24,285,841	690,405.00	35.18	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/27/2015 6:07 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	2,126,930	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)	1,687,399	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	39,107	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)	17,938,548	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	199,449	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	89,812	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)	417,204	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	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	6,553,950	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	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	38,957	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	29,091,356	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet S-3
Part V
Date/Time Prepared:
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Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/27/2015 6:07 pm
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				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)		0.230171		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		41,149,892		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		285,085,454		6.00
7.00	Medicaid cost (line 1 times line 6)		65,618,404		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)		24,468,512		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)		24,468,512		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	4,092,904	1,302,917	5,395,821	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	942,068	299,894	1,241,962	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)	942,068	299,894	1,241,962	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)			31,653,289	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			8,881	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			31,644,408	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			7,283,625	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			8,525,587	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			32,994,099	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A
Date/Time Prepared:
5/27/2015 6:07 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	17,396,595	17,396,595	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	13,499,012	13,499,012	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	327,784	15,806,078	16,133,862	-146,758	15,987,104	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,205,703	108,856,460	120,062,163	-20,067,020	99,995,143	5.00
7.00	00700	OPERATION OF PLANT	2,378,951	6,717,355	9,096,306	750,899	9,847,205	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	789,738	789,738	-79	789,659	8.00
9.00	00900	HOUSEKEEPING	1,930,340	975,703	2,906,043	-29,454	2,876,589	9.00
10.00	01000	DIETARY	2,262,879	434,808	2,697,687	-1,317,835	1,379,852	10.00
11.00	01100	CAFETERIA	0	0	0	1,417,187	1,417,187	11.00
13.00	01300	NURSING ADMINISTRATION	511,034	2,174,785	2,685,819	-932	2,684,887	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,645,778	1,645,778	-97,001	1,548,777	14.00
15.00	01500	PHARMACY	3,259,413	10,008,970	13,268,383	-10,909,323	2,359,060	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	460,823	2,798,027	3,258,850	-178	3,258,672	16.00
17.00	01700	SOCIAL SERVICE	1,806,039	770,047	2,576,086	-391	2,575,695	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	EMS TRAINING PROGRAM-ALLIED HEALTH	0	0	0	32,961	32,961	23.00
23.01	02301	RADIOLOGY SCHOOL-ALLIED HEALTH	0	41,687	41,687	6,368	48,055	23.01
23.02	02302	PHARMACY RESIDENCY-ALLIED HEALTH	0	0	0	223,260	223,260	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,824,971	8,037,482	34,862,453	-12,508,875	22,353,578	30.00
31.00	03100	INTENSIVE CARE UNIT	3,299,245	856,277	4,155,522	-218,719	3,936,803	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	5,103,305	1,275,095	6,378,400	-316,263	6,062,137	35.00
40.00	04000	SUBPROVIDER - I PF	1,090,831	162,121	1,252,952	-19,738	1,233,214	40.00
41.00	04100	SUBPROVIDER - I RF	0	251	251	-251	0	41.00
43.00	04300	NURSERY	0	0	0	2,358,423	2,358,423	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,803,650	30,179,499	34,983,149	-24,361,953	10,621,196	50.00
51.00	05100	RECOVERY ROOM	1,945,478	506,953	2,452,431	-211,530	2,240,901	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	426,131	426,131	6,360,925	6,787,056	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,248,948	2,428,026	5,676,974	-1,523,914	4,153,060	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	318,734	1,401,656	1,720,390	-984,729	735,661	55.00
57.00	05700	CT SCAN	710,198	732,687	1,442,885	79,799	1,522,684	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	595,639	4,093,367	4,689,006	-556,808	4,132,198	58.00
60.00	06000	LABORATORY	0	6,669,099	6,669,099	-3,448	6,665,651	60.00
64.00	06400	INTRAVENOUS THERAPY	290,956	146,191	437,147	-100,533	336,614	64.00
65.00	06500	RESPIRATORY THERAPY	2,692,750	860,745	3,553,495	-424,311	3,129,184	65.00
66.00	06600	PHYSICAL THERAPY	4,182,549	1,840,820	6,023,369	-762,124	5,261,245	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,352,663	1,352,663	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	308,539	308,539	68.00
69.00	06900	ELECTROCARDIOLOGY	31,719	1,443,922	1,475,641	-17,719	1,457,922	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	762,817	838,938	1,601,755	-227,990	1,373,765	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,406,302	10,406,302	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,938,495	13,938,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,287,303	10,287,303	73.00
74.00	07400	RENAL DIALYSIS	0	647,891	647,891	-6,312	641,579	74.00
76.00	03330	ENDOSCOPY	895,295	1,245,850	2,141,145	-872,994	1,268,151	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0	0	76.05
76.06	03954	IMAGING CENTER	1,251,688	2,840,182	4,091,870	-1,131,798	2,960,072	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	5,524,163	5,524,163	-63,924	5,460,239	76.07
76.08	03956	BARIATRIC CLINIC	3,992	5,979	9,971	-212	9,759	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	85,582	85,582	0	85,582	90.24
90.26	04975	SPINE CENTER	175,739	74,810	250,549	-60,749	189,800	90.26
90.27	04976	DIABETIC CARE CENTER	0	2,347	2,347	0	2,347	90.27
91.00	09100	EMERGENCY	5,665,969	2,248,988	7,914,957	-307,484	7,607,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,037,439	225,594,488	313,631,927	1,167,382	314,799,309	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	24,233	24,233	0	24,233	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	876,328	7,042,136	7,918,464	0	7,918,464	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A
Date/Time Prepared:
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Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 HOME OFFICE	0	0	0	0	0	194.00
194.06 07956 PAVILLIONS	0	2,683,781	2,683,781	-1,104,807	1,578,974	194.06
194.07 07957 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08 07958 OTHER NONREIMBURSABLE COST CENTERS	233,815	1,134,036	1,367,851	-51,726	1,316,125	194.08
194.09 07959 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10 07960 COMMUNITY REHAB HOSPITAL	302,740	44,675	347,415	-10,849	336,566	194.10
194.11 07961 WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
200.00 TOTAL (SUM OF LINES 118-199)	89,450,322	236,523,349	325,973,671	0	325,973,671	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A
Date/Time Prepared:
5/27/2015 6:07 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-9,690,557	7,706,038	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,705,957	17,204,969	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-150,331	15,836,773	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-58,969,493	41,025,650	5.00
7.00	00700	OPERATION OF PLANT	-113,127	9,734,078	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	789,659	8.00
9.00	00900	HOUSEKEEPING	0	2,876,589	9.00
10.00	01000	DIETARY	-8,591	1,371,261	10.00
11.00	01100	CAFETERIA	-54,869	1,362,318	11.00
13.00	01300	NURSING ADMINISTRATION	-212,370	2,472,517	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,548,777	14.00
15.00	01500	PHARMACY	-4,974	2,354,086	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,258,672	16.00
17.00	01700	SOCIAL SERVICE	0	2,575,695	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	109,353	109,353	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	186,788	186,788	22.00
23.00	02300	EMS TRAINING PROGRAM-ALLIED HEALTHEM	53,751	86,712	23.00
23.01	02301	RADIOLOGY SCHOOL-ALLIED HEALTH	-41,687	6,368	23.01
23.02	02302	PHARMACY RESIDENCY-ALLIED HEALTH	246,750	470,010	23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-62,839	22,290,739	30.00
31.00	03100	INTENSIVE CARE UNIT	214,074	4,150,877	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	6,062,137	35.00
40.00	04000	SUBPROVIDER - I PF	0	1,233,214	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
43.00	04300	NURSERY	0	2,358,423	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-37,298	10,583,898	50.00
51.00	05100	RECOVERY ROOM	0	2,240,901	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,787,056	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-79,419	4,073,641	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	735,661	55.00
57.00	05700	CT SCAN	0	1,522,684	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-434,775	3,697,423	58.00
60.00	06000	LABORATORY	-2,860,603	3,805,048	60.00
64.00	06400	INTRAVENOUS THERAPY	0	336,614	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,129,184	65.00
66.00	06600	PHYSICAL THERAPY	-219,295	5,041,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,352,663	67.00
68.00	06800	SPEECH PATHOLOGY	0	308,539	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,457,922	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,373,765	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,406,302	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,938,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,287,303	73.00
74.00	07400	RENAL DIALYSIS	0	641,579	74.00
76.00	03330	ENDOSCOPY	0	1,268,151	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	76.05
76.06	03954	IMAGING CENTER	-145,050	2,815,022	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	5,460,239	76.07
76.08	03956	BARIATRIC CLINIC	0	9,759	76.08
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.24	04973	PALLIATIVE CARE	-85,582	0	90.24
90.26	04975	SPINE CENTER	0	189,800	90.26
90.27	04976	DIABETIC CARE CENTER	-2,347	0	90.27
91.00	09100	EMERGENCY	-121,803	7,485,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-68,778,337	246,020,972	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	24,233	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,918,464	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	HOME OFFICE	0	0	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A
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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.06	07956	PAVILLIONS	0	1,578,974	194.06
194.07	07957	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.07
194.08	07958	OTHER NONREIMBURSABLE COST CENTERS	0	1,316,125	194.08
194.09	07959	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.09
194.10	07960	COMMUNITY REHAB HOSPITAL	0	336,566	194.10
194.11	07961	WALGREENS TAKE CARE CLINIC	0	0	194.11
200.00		TOTAL (SUM OF LINES 118-199)	-68,778,337	257,195,334	200.00

RECLASSIFICATIONS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-6

Date/Time Prepared:
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		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - Labor and Delivery Salary						
1.00	NURSERY	43.00	1,794,047			1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4,838,740			2.00
			6,632,787	0		
B - Labor and Delivery Other						
1.00	NURSERY	43.00	0	564,376		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,522,185		2.00
	TOTALS		0	2,086,561		
C - Chargeable Medical Supplies						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	565,600		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,406,302		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	TOTALS		0	10,971,902		
D - Depreciation Expense						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,296,110		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
	TOTALS		0	17,296,110		
E - Radiology Support Salary						
1.00	RADIOLOGY-THERAPEUTIC	55.00	48,441			1.00
2.00	CT SCAN	57.00	141,365			2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	46,135			3.00
			235,941	0		

RECLASSIFICATIONS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-6
Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
F - Radiology Support Other					
1.00	RADIOLOGY-THERAPEUTIC	55.00	0	70,780	1.00
2.00	CT SCAN	57.00	0	206,552	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	67,410	3.00
TOTALS			0	344,742	
G - Capital Insurance Costs					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	204,484	1.00
TOTALS			0	204,484	
H - Implantable Device Recl ass					
1.00	CENTRAL SERVICES & SUPPLY	14.00		676,027	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		13,938,495	2.00
3.00					3.00
4.00					4.00
5.00					5.00
6.00					6.00
7.00			0	14,614,522	7.00
I - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,658,883	1.00
TOTALS			0	8,658,883	
J - Other Capital Rental Recl ass					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,795,425	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,940,705	2.00
3.00	OPERATION OF PLANT	7.00	0	18,208	3.00
4.00	DIETARY	10.00	0	286	4.00
5.00	RESPIRATORY THERAPY	65.00	0	26,557	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
TOTALS			0	4,781,181	
K - Depreciation by CC					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,737,803	1.00
TOTALS			0	6,737,803	
L - Cafeteria Salary					
1.00	CAFETERIA	11.00	1,202,971		1.00
			1,202,971	0	
M - Cafeteria Recl ass					
1.00	CAFETERIA	11.00		214,216	1.00
			0	214,216	
N - PHARMACY PRECEPTOR SALARY RECLASS					
1.00	PHARMACY RESIDENCY-ALLIED HEALTH	23.02	200,245	0	1.00
TOTALS			200,245	0	
O - Pharmacy Residency Preceptor Recl ass					
1.00	PHARMACY RESIDENCY-ALLIED HEALTH	23.02		23,015	1.00
			0	23,015	
Q - Drugs Charges to Pat					
1.00	DRUGS CHARGED TO PATIENTS	73.00		10,287,303	1.00
2.00					2.00
3.00					3.00

RECLASSIFICATIONS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-6

Date/Time Prepared:
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						Increases					
Cost Center		Line #	Salary	Other							
2.00		3.00	4.00	5.00							
4.00										4.00	
5.00										5.00	
6.00										6.00	
7.00										7.00	
8.00										8.00	
9.00										9.00	
10.00										10.00	
11.00										11.00	
12.00										12.00	
13.00										13.00	
14.00										14.00	
			0	10,287,303							
R - Therapy Salary											
1.00	OCCUPATIONAL THERAPY	67.00	955,078							1.00	
2.00	SPEECH PATHOLOGY	68.00	217,851							2.00	
			1,172,929	0							
S - Therapy Other											
1.00	PHYSICAL THERAPY	66.00		1,252,860						1.00	
2.00	OCCUPATIONAL THERAPY	67.00		397,585						2.00	
3.00	SPEECH PATHOLOGY	68.00		90,688						3.00	
			0	1,741,133							
T - Plant Operations Expense											
1.00	OPERATION OF PLANT	7.00	0	883,896						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	
TOTALS			0	883,896							
U - Dietary Food Service Allocation											
1.00	DIETARY	10.00	0	191,548						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	
TOTALS			0	191,548							
V - STD BENEFIT RECLASS											
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,559						1.00	
2.00	OPERATION OF PLANT	7.00	0	10,574						2.00	
3.00	HOUSEKEEPING	9.00	0	25,472						3.00	
4.00	DIETARY	10.00	0	8,966						4.00	
5.00	NURSING ADMINISTRATION	13.00	0	1,828						5.00	
6.00	PHARMACY	15.00	0	23,591						6.00	
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,860						7.00	
8.00	SOCIAL SERVICE	17.00	0	2,010						8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	156,717						9.00	

RECLASSIFICATIONS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-6

Date/Time Prepared:
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
10.00	INTENSIVE CARE UNIT	31.00	0	16,458	10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	23,399	11.00
12.00	SUBPROVIDER - IPF	40.00	0	3,347	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,338	13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	7,439	14.00
15.00	RESPIRATORY THERAPY	65.00	0	15,849	15.00
16.00	PHYSICAL THERAPY	66.00	0	13,045	16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	874	17.00
18.00	IMAGING CENTER	76.06	0	3,907	18.00
19.00	EMERGENCY	91.00	0	37,962	19.00
20.00	COMMUNITY REHAB HOSPITAL	194.10	0	600	20.00
	TOTALS		0	389,795	
W - EMS School Allied Health					
1.00	EMS TRAINING PROGRAM-ALLIED HEALTH	23.00	22,936	0	1.00
			22,936	0	
X - EMS School Allied Health					
1.00	EMS TRAINING PROGRAM-ALLIED HEALTH	23.00	0	10,025	1.00
			0	10,025	
Y - Radiology School Allied Health					
1.00	RADIOLOGY SCHOOL-ALLIED HEALTH	23.01	5,915	0	1.00
			5,915	0	
Z - Radiology School Allied Health					
1.00	RADIOLOGY SCHOOL-ALLIED HEALTH	23.01	0	453	1.00
			0	453	
500.00	Grand Total: Increases		9,473,724	79,437,572	500.00

RECLASSIFICATIONS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-6
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - Labor and Delivery Salary							
1.00	ADULTS & PEDIATRICS	30.00	6,632,787				1.00
2.00							2.00
			6,632,787		0		
B - Labor and Delivery Other							
1.00	ADULTS & PEDIATRICS	30.00	0	2,086,561		0	1.00
2.00		0.00		0		0	2.00
TOTALS			0	2,086,561			
C - Chargeable Medical Supplies							
1.00	OPERATION OF PLANT	7.00	0	51,607		0	1.00
2.00	DIETARY	10.00	0	2,256		0	2.00
3.00	PHARMACY	15.00	0	51,462		0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	1,147,450		0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	180,702		0	5.00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	109,006		0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	1,366		0	7.00
8.00	SUBPROVIDER - IRF	41.00	0	3		0	8.00
9.00	OPERATING ROOM	50.00	0	7,169,544		0	9.00
10.00	RECOVERY ROOM	51.00	0	188,810		0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42,837		0	11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	680,844		0	12.00
13.00	CT SCAN	57.00	0	125,469		0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	7,263		0	14.00
15.00	INTRAVENOUS THERAPY	64.00	0	97,336		0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	290,143		0	16.00
17.00	PHYSICAL THERAPY	66.00	0	12,278		0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	48,992		0	18.00
19.00	RENAL DIALYSIS	74.00	0	6,177		0	19.00
20.00	ENDOSCOPY	76.00	0	524,083		0	20.00
21.00	IMAGING CENTER	76.06	0	48,758		0	21.00
22.00	BREAST DIAGNOSTIC CENTER	76.07	0	771		0	22.00
23.00	EMERGENCY	91.00	0	181,414		0	23.00
24.00	OTHER NONREIMBURSABLE COST CENTERS	194.08	0	3,331		0	24.00
TOTALS			0	10,971,902			
D - Depreciation Expense							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17,758		9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	10,954,084		0	2.00
3.00	OPERATION OF PLANT	7.00	0	99,598		0	3.00
4.00	HOUSEKEEPING	9.00	0	9,596		0	4.00
5.00	DIETARY	10.00	0	66,385		0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	853		0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	69,769		0	7.00
8.00	PHARMACY	15.00	0	148,795		0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	719,378		0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	31,308		0	10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	191,954		0	11.00
12.00	SUBPROVIDER - IPF	40.00	0	17,890		0	12.00
13.00	OPERATING ROOM	50.00	0	1,548,913		0	13.00
14.00	RECOVERY ROOM	51.00	0	22,300		0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	781,940		0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	144,144		0	16.00
17.00	CT SCAN	57.00	0	38,258		0	17.00
18.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	590,522		0	18.00
19.00	LABORATORY	60.00	0	1,082		0	19.00
20.00	INTRAVENOUS THERAPY	64.00	0	3,000		0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	145,229		0	21.00
22.00	PHYSICAL THERAPY	66.00	0	99,687		0	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	17,719		0	23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	89,498		0	24.00
25.00	ENDOSCOPY	76.00	0	255,622		0	25.00
26.00	IMAGING CENTER	76.06	0	672,014		0	26.00
27.00	BREAST DIAGNOSTIC CENTER	76.07	0	63,153		0	27.00
28.00	EMERGENCY	91.00	0	56,267		0	28.00
29.00	PAVILLIONS	194.06	0	431,641		0	29.00
30.00	OTHER NONREIMBURSABLE COST CENTERS	194.08	0	7,753		0	30.00
TOTALS			0	17,296,110			
E - Radiology Support Salary							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	235,941				1.00
2.00							2.00
3.00							3.00

RECLASSIFICATIONS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

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Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
		235,941	0			
F - Radiology Support Other						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	344,742	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	344,742		
G - Capital Insurance Costs						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	204,484	12	1.00
	TOTALS		0	204,484		
H - Implantable Device Recl ass						
1.00	ADMINISTRATIVE & GENERAL	5.00		9,600		1.00
2.00	PHARMACY	15.00		7		2.00
3.00	ADULTS & PEDIATRICS	30.00		982		3.00
4.00	OPERATING ROOM	50.00		14,231,228		4.00
5.00	RADIOLOGY-THERAPEUTIC	55.00		278,018		5.00
6.00	PHYSICAL THERAPY	66.00		5,474		6.00
7.00	ENDOSCOPY	76.00		89,213		7.00
	TOTALS		0	14,614,522		
I - Interest Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,658,883	11	1.00
	TOTALS		0	8,658,883		
J - Other Capital Rental Recl ass						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	128,400	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	239,842	10	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	79	0	3.00
4.00	HOUSEKEEPING	9.00	0	1,068	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	79	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,263,741	0	6.00
7.00	PHARMACY	15.00	0	331,552	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	178	0	8.00
9.00	SOCIAL SERVICE	17.00	0	391	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	0	23,844	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	612	0	11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	514	0	12.00
13.00	SUBPROVIDER - IPF	40.00	0	482	0	13.00
14.00	SUBPROVIDER - IRF	41.00	0	174	0	14.00
15.00	OPERATING ROOM	50.00	0	1,223,143	0	15.00
16.00	RECOVERY ROOM	51.00	0	394	0	16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,557	0	17.00
18.00	RADIOLOGY-THERAPEUTIC	55.00	0	665	0	18.00
19.00	CT SCAN	57.00	0	102,810	0	19.00
20.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	68,339	0	20.00
21.00	INTRAVENOUS THERAPY	64.00	0	197	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	719,206	0	22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	83,661	0	23.00
24.00	ENDOSCOPY	76.00	0	713	0	24.00
25.00	IMAGING CENTER	76.06	0	399,702	0	25.00
26.00	SPI NE CENTER	90.26	0	51,108	0	26.00
27.00	EMERGENCY	91.00	0	4,133	0	27.00
28.00	PAVILLIONS	194.06	0	93,955	0	28.00
29.00	OTHER NONREIMBURSABLE COST CENTERS	194.08	0	40,642	0	29.00
	TOTALS		0	4,781,181		
K - Depreciation by CC						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,737,803	9	1.00
	TOTALS		0	6,737,803		
L - Cafeteria Salary						
1.00	DIETARY	10.00	1,202,971			1.00
			1,202,971	0		
M - Cafeteria Recl ass						
1.00	DIETARY	10.00		214,216		1.00
			0	214,216		
N - PHARMACY PRECEPTOR SALARY RECLASS						
1.00	PHARMACY	15.00	200,245	0	0	1.00
	TOTALS		200,245	0		
O - Pharmacy Residency Preceptor Recl ass						
1.00	PHARMACY	15.00		23,015		1.00
			0	23,015		
Q - Drugs Charges to Pat						
1.00	CENTRAL SERVICES & SUPPLY	14.00		350		1.00
2.00	PHARMACY	15.00		10,154,247		2.00
3.00	ADULTS & PEDIATRICS	30.00		430		3.00
4.00	INTENSIVE CARE UNIT	31.00		205		4.00

RECLASSIFICATIONS

Provider CCN: 150169

Period:
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To 12/31/2014

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
5.00	NEONATAL INTENSIVE CARE UNIT	35.00		48			5.00
6.00	OPERATING ROOM	50.00		459			6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00		105,684			7.00
8.00	RESPIRATORY THERAPY	65.00		4,276			8.00
9.00	PHYSICAL THERAPY	66.00		839			9.00
10.00	IMAGING CENTER	76.06		243			10.00
11.00	BARIATRIC CLINIC	76.08		96			11.00
12.00	SPINE CENTER	90.26		9,197			12.00
13.00	EMERGENCY	91.00		380			13.00
14.00	COMMUNITY REHAB HOSPITAL	194.10		10,849			14.00
			0	10,287,303			
R - Therapy Salary							
1.00	PHYSICAL THERAPY	66.00	1,172,929				1.00
2.00							2.00
			1,172,929	0			
S - Therapy Other							
1.00	ADULTS & PEDIATRICS	30.00		1,741,133			1.00
2.00							2.00
3.00							3.00
			0	1,741,133			
T - Plant Operations Expense							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	600	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	127	0		2.00
3.00	HOUSEKEEPING	9.00	0	18,790	0		3.00
4.00	DIETARY	10.00	0	23,841	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,768	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	32,854	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	1,070	0		7.00
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	10,337	0		8.00
9.00	OPERATING ROOM	50.00	0	170,307	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,702	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	279	0		11.00
12.00	CT SCAN	57.00	0	955	0		12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,062	0		13.00
14.00	LABORATORY	60.00	0	2,366	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	10,252	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	3,752	0		16.00
17.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,414	0		17.00
18.00	RENAL DIALYSIS	74.00	0	135	0		18.00
19.00	ENDOSCOPY	76.00	0	2,432	0		19.00
20.00	IMAGING CENTER	76.06	0	6,846	0		20.00
21.00	EMERGENCY	91.00	0	7,796	0		21.00
22.00	PAVILLIONS	194.06	0	579,211	0		22.00
	TOTALS		0	883,896			
U - Dietary Food Service Allocation							
1.00	ADULTS & PEDIATRICS	30.00	0	123,456	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	4,822	0		2.00
3.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	4,404	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	74	0		4.00
5.00	OPERATING ROOM	50.00	0	18,359	0		5.00
6.00	RECOVERY ROOM	51.00	0	26	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,143	0		7.00
8.00	CT SCAN	57.00	0	626	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	167	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	968	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	819	0		11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,425	0		12.00
13.00	ENDOSCOPY	76.00	0	931	0		13.00
14.00	IMAGING CENTER	76.06	0	4,235	0		14.00
15.00	BARIATRIC CLINIC	76.08	0	116	0		15.00
16.00	SPINE CENTER	90.26	0	444	0		16.00
17.00	EMERGENCY	91.00	0	24,533	0		17.00
	TOTALS		0	191,548			
V - STD BENEFIT RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	26,559	0	0		1.00
2.00	OPERATION OF PLANT	7.00	10,574	0	0		2.00
3.00	HOUSEKEEPING	9.00	25,472	0	0		3.00
4.00	DIETARY	10.00	8,966	0	0		4.00
5.00	NURSING ADMINISTRATION	13.00	1,828	0	0		5.00
6.00	PHARMACY	15.00	23,591	0	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	4,860	0	0		7.00
8.00	SOCIAL SERVICE	17.00	2,010	0	0		8.00

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-6
Date/Time Prepared:
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Decreases								
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.			
6.00	7.00	8.00	9.00	10.00				
9.00	ADULTS & PEDIATRICS	30.00	156,717	0	0		9.00	
10.00	INTENSIVE CARE UNIT	31.00	16,458	0	0		10.00	
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	23,399	0	0		11.00	
12.00	SUBPROVIDER - IPF	40.00	3,347	0	0		12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	6,338	0	0		13.00	
14.00	RADIOLOGY-THERAPEUTIC	55.00	7,439	0	0		14.00	
15.00	RESPIRATORY THERAPY	65.00	15,849	0	0		15.00	
16.00	PHYSICAL THERAPY	66.00	13,045	0	0		16.00	
17.00	ELECTROENCEPHALOGRAPHY	70.00	874	0	0		17.00	
18.00	IMAGING CENTER	76.00	3,907	0	0		18.00	
19.00	EMERGENCY	91.00	37,962	0	0		19.00	
20.00	COMMUNITY REHAB HOSPITAL	194.10	600	0	0		20.00	
	TOTALS		389,795	0				
W - EMS School Allied Health								
1.00	EMERGENCY	91.00	22,936				1.00	
			22,936	0				
X - EMS School Allied Health								
1.00	EMERGENCY	91.00		10,025			1.00	
			0	10,025				
Y - Radiology School Allied Health								
1.00	RADIOLOGY-DIAGNOSTIC	54.00	5,915				1.00	
			5,915	0				
Z - Radiology School Allied Health								
1.00	RADIOLOGY-DIAGNOSTIC	54.00		453			1.00	
			0	453				
500.00	Grand Total : Decreases		9,863,519	79,047,777			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-7
Part I
Date/Time Prepared:
5/27/2015 6:07 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	2,705,851	0	0	0	1.00
2.00	Land Improvements	3,158,137	0	0	0	2.00
3.00	Buildings and Fixtures	289,972,896	1,602,044	0	1,602,044	3.00
4.00	Building Improvements	5,326,285	3,117	0	3,117	4.00
5.00	Fixed Equipment	3,118,039	0	0	0	5.00
6.00	Movable Equipment	90,711,081	6,884,162	0	6,884,162	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	394,992,289	8,489,323	0	8,489,323	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	394,992,289	8,489,323	0	8,489,323	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,705,851	0			1.00
2.00	Land Improvements	3,158,137	0			2.00
3.00	Buildings and Fixtures	291,574,940	0			3.00
4.00	Building Improvements	4,977,715	0			4.00
5.00	Fixed Equipment	3,118,039	0			5.00
6.00	Movable Equipment	92,087,813	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	397,622,495	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	397,622,495	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2015 6:07 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prepared: 5/27/2015 6:07 pm
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	394,992,289	0	394,992,289	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	394,992,289	0	394,992,289	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	7,305,453	1,795,425	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	14,264,264	2,940,705	2.00
3.00	Total (sum of lines 1-2)	0	0	0	21,569,717	4,736,130	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-1,599,324	204,484	0	0	7,706,038	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	17,204,969	2.00
3.00	Total (sum of lines 1-2)	-1,599,324	204,484	0	0	24,911,007	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-29,853		ADMINISTRATIVE & GENERAL	5.00		0	7.00
8.00 Television and radio service (chapter 21)	A	-27,363		CAP REL COSTS-MVBLE EQUIP	2.00		9	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-99,629					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	285,554					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests			0		0.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts			0		0.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines			0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)				*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	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			OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 Misc Revenue	B	-114,371		EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.00
33.01 Misc Revenue	B	-593,396		ADMINISTRATIVE & GENERAL	5.00		0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-8

Date/Time Prepared:
5/27/2015 6:07 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
33.02	Misc Revenue	B	-93,127	OPERATION OF PLANT	7.00	0	33.02
33.03	Misc Revenue	B	-212,370	NURSING ADMINISTRATION	13.00	0	33.03
33.04	Misc Revenue	B	-4,974	PHARMACY	15.00	0	33.04
33.05	Misc Revenue	B	-32,509	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	Misc Revenue	B	-37,298	OPERATING ROOM	50.00	0	33.06
33.07	Misc Revenue	B	-434,775	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.07
33.08	Misc Revenue	B	-213,370	PHYSICAL THERAPY	66.00	0	33.08
33.13	Misc Rev 35100	B	-20,000	OPERATION OF PLANT	7.00	0	33.13
33.14	Misc Rev 35100	B	-1,323	DIETARY	10.00	0	33.14
33.15	Misc Revenue 35200	B	-35,960	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	Misc Revenue 35200	B	-7,268	DIETARY	10.00	0	33.16
33.17	Misc Revenue 35200	B	-30,330	ADULTS & PEDIATRICS	30.00	0	33.17
33.18	Misc Revenue 35200	B	-79,419	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.20	Leased Equipment CBI	B	-6,563,151	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.22	VEI Interest Income Loans	B	-239,325	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.24	Interest Income IHH Building Loan	B	-1,853,247	CAP REL COSTS-BLDG & FIXT	1.00	11	33.24
33.26	Space Rental Income IHH and OLI	B	-145,050	IMAGING CENTER	76.06	0	33.26
33.27	Equity Investment Gain/Loss	B	-5,364,647	CAP REL COSTS-BLDG & FIXT	1.00	11	33.27
34.00	00 Non-Allow Interest Expense	A	-7,331	CAP REL COSTS-BLDG & FIXT	1.00	11	34.00
34.01	00 Non-Allow Interest Expense	A	-123,917	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	LOC Non-Allow Interest Expense	A	-31,411	ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.03	92 Non-Allow Interest Expense	A	-2,580,191	CAP REL COSTS-BLDG & FIXT	1.00	11	34.03
34.04	92 Non-Allow Interest Expense	A	123,824	ADMINISTRATIVE & GENERAL	5.00	0	34.04
34.05	12B Non-Allow Interest Expense	A	-117,464	CAP REL COSTS-BLDG & FIXT	1.00	11	34.05
34.06	12B Non-Allow Interest Expense	A	-1,403	ADMINISTRATIVE & GENERAL	5.00	0	34.06
34.07	50M BMO Non-Allow Interest Expense	A	-335,327	CAP REL COSTS-BLDG & FIXT	1.00	11	34.07
35.00	HAF Tax Offset	A	-16,748,393	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	Bad Debt Expense	A	-31,527,509	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.15	Medical Director Allocation	A	131,839	ADMINISTRATIVE & GENERAL	5.00	0	35.15
35.16	Medical Director Allocation	A	214,074	INTENSIVE CARE UNIT	31.00	0	35.16
35.17	Pension Adjustment	A	-1,686,391	ADMINISTRATIVE & GENERAL	5.00	0	35.17
35.18			0		0.00	0	35.18
35.21			0		0.00	0	35.21
36.02	Sponsorship	A	-40,896	ADMINISTRATIVE & GENERAL	5.00	0	36.02
36.03	Non Allow Marketing Expense	A	-93,684	ADMINISTRATIVE & GENERAL	5.00	0	36.03
36.04	Meals of Wheels Cost	A	-54,869	CAFETERIA	11.00	0	36.04
36.06	EMS Training Allied Health_Expense Onset	A	53,751	EMS TRAINING PROGRAM-ALLIED HEALTHEM	23.00	0	36.06
36.07	Patient Phone Cost - Depreciation	A	-1,169	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.07
36.08	INTERHOSPITAL ALLOCATION PALLIATIVE CARE AND DCC	A	-85,582	PALLIATIVE CARE	90.24	0	36.08
36.09	INTERHOSPITAL ALLOCATION PALLIATIVE CARE AND DCC	A	-2,347	DIABETIC CARE CENTER	90.27	0	36.09
36.11	Pharmacy Residency Expense	A	246,750	PHARMACY RESIDENCY-ALLIED HEALTH	23.02	0	36.11
36.12	INTERHOSPITAL ALLOCATION ALLIED HEALTH	A	-41,687	RADIOLOGY SCHOOL-ALLIED HEALTH	23.01	0	36.12
36.13	INTERHOSPITAL ALLOCATION ALLIED HEALTH	A	-121,803	EMERGENCY	91.00	0	36.13
36.14			0		0.00	0	36.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-68,778,337				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150169

Period: From 01/01/2014 To 12/31/2014

Worksheet A-8-1

Date/Time Prepared: 5/27/2015 6:07 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	22.00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	186,788	0 1.00
2.00	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	109,353	0 2.00
3.00	60.00	LABORATORY	PURCHASED LAB SERVICES	4,009,077	6,869,680 3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	CHNW - HOME OFFICE	567,650	0 4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	CHNW - HOME OFFICE	3,734,489	0 4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	CHNW - HOME OFFICE	16,363,992	17,816,115 4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			24,971,349	24,685,795 5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-8-1

Date/Time Prepared:
5/27/2015 6:07 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	186,788	0		1.00
2.00	109,353	0		2.00
3.00	-2,860,603	0		3.00
4.00	567,650	9		4.00
4.01	3,734,489	9		4.01
4.02	-1,452,123	0		4.02
5.00	285,554			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet A-8-2

Date/Time Prepared:
5/27/2015 6:07 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	93,704	93,704	0	0	0	1.00
2.00	66.00	AGGREGATE-PHYSICAL THERAPY	5,925	5,925	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			99,629	99,629	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	66.00	AGGREGATE-PHYSICAL THERAPY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	93,704		1.00
2.00	66.00	AGGREGATE-PHYSICAL THERAPY	0	0	0	5,925		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	99,629		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,706,038	7,706,038			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	17,204,969		17,204,969		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	15,836,773	12,180	17,664	15,866,617	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	41,025,650	866,505	10,896,367	1,998,987	5.00
7.00 00700	OPERATION OF PLANT	9,734,078	1,027,490	99,073	423,499	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	789,659	26,469	0	0	8.00
9.00 00900	HOUSEKEEPING	2,876,589	47,366	9,545	340,617	9.00
10.00 01000	DIETARY	1,371,261	93,334	25,001	187,923	10.00
11.00 01100	CAFETERIA	1,362,318	153,186	41,035	215,108	11.00
13.00 01300	NURSING ADMINISTRATION	2,472,517	41,882	849	91,053	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,548,777	172,051	69,401	0	14.00
15.00 01500	PHARMACY	2,354,086	82,366	148,011	542,804	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,258,672	10,356	0	81,533	16.00
17.00 01700	SOCIAL SERVICE	2,575,695	17,260	0	322,586	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	109,353	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	186,788	0	0	0	22.00
23.00 02300	EMS TRAINING PROGRAM-ALLIED HEALTHEM	86,712	9,329	0	4,101	23.00
23.01 02301	RADIOLOGY SCHOOL-ALLIED HEALTH	6,368	350	0	1,058	23.01
23.02 02302	PHARMACY RESIDENCY-ALLIED HEALTH	470,010	0	0	35,807	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	22,290,739	1,978,205	539,612	3,582,582	30.00
31.00 03100	INTENSIVE CARE UNIT	4,150,877	241,625	31,143	587,008	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	6,062,137	455,439	190,942	908,358	35.00
40.00 04000	SUBPROVIDER - I PF	1,233,214	125,505	17,796	194,457	40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	41.00
43.00 04300	NURSERY	2,358,423	230,123	47,598	320,801	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	10,583,898	351,826	1,540,750	858,960	50.00
51.00 05100	RECOVERY ROOM	2,240,901	146,096	22,182	347,879	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,787,056	620,663	128,377	865,234	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,073,641	128,410	759,360	536,577	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	735,661	88,964	147,174	64,326	55.00
57.00 05700	CT SCAN	1,522,684	16,178	49,117	152,271	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	3,697,423	58,771	591,019	114,758	58.00
60.00 06000	LABORATORY	3,805,048	65,478	1,076	0	60.00
64.00 06400	INTRAVENOUS THERAPY	336,614	2,196	2,984	52,027	64.00
65.00 06500	RESPIRATORY THERAPY	3,129,184	70,830	144,464	478,667	65.00
66.00 06600	PHYSICAL THERAPY	5,041,950	0	71,354	535,830	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,352,663	0	22,643	170,781	67.00
68.00 06800	SPEECH PATHOLOGY	308,539	0	5,165	38,955	68.00
69.00 06900	ELECTROCARDIOLOGY	1,457,922	0	17,626	5,672	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,373,765	17,293	89,026	136,246	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,406,302	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	13,938,495	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	10,287,303	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	641,579	2,163	0	0	74.00
76.00 03330	ENDOSCOPY	1,268,151	91,356	254,275	160,091	76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.02 03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	76.02
76.03 03951	OTHER ANCILLARY SERVICES	0	0	0	0	76.03
76.04 03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.04
76.05 03953	MISC ANCILLARY	0	0	0	0	76.05
76.06 03954	IMAGING CENTER	2,815,022	0	668,472	223,121	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	5,460,239	0	62,820	0	76.07
76.08 03956	BARIATRIC CLINIC	9,759	0	0	714	76.08
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.24 04973	PALLIATIVE CARE	0	0	0	0	90.24
90.26 04975	SPIRE CENTER	189,800	0	0	31,425	90.26
90.27 04976	DIABETIC CARE CENTER	0	0	0	0	90.27
91.00 09100	EMERGENCY	7,485,670	358,205	55,970	1,002,265	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	246,020,972	7,609,450	16,767,891	15,614,081	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,015	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
191.00 19100 RESEARCH	24,233	0	0	0	24,233	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	7,918,464	9,700	0	156,700	8,084,864	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 HOME OFFICE	0	48,873	0	0	48,873	194.00
194.06 07956 PAVILIONS	1,578,974	0	429,366	0	2,008,340	194.06
194.07 07957 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08 07958 OTHER NONREIMBURSABLE COST CENTERS	1,316,125	0	7,712	41,809	1,365,646	194.08
194.09 07959 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10 07960 COMMUNITY REHAB HOSPITAL	336,566	0	0	54,027	390,593	194.10
194.11 07961 WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 TOTAL (sum lines 118-201)	257,195,334	7,706,038	17,204,969	15,866,617	257,195,334	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared: 5/27/2015 6:07 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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	54,787,509					5.00
7.00	00700	OPERATION OF PLANT	3,054,380	14,338,520				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	220,909	65,436	1,102,473			8.00
9.00	00900	HOUSEKEEPING	886,235	117,099	0	4,277,451		9.00
10.00	01000	DIETARY	454,069	230,741	0	69,722	2,432,051	10.00
11.00	01100	CAFETERIA	479,548	378,708	0	114,433	0	11.00
13.00	01300	NURSING ADMINISTRATION	705,471	103,542	0	31,287	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	484,577	425,348	0	128,525	0	14.00
15.00	01500	PHARMACY	846,486	203,627	0	61,529	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	906,927	25,602	0	7,736	0	16.00
17.00	01700	SOCIAL SERVICE	789,176	42,670	0	12,893	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	29,600	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	50,560	0	0	0	0	22.00
23.00	02300	EMS TRAINING PROGRAM-ALLIED HEALTHEM	27,106	23,063	0	6,969	0	23.00
23.01	02301	RADIOLOGY SCHOOL-ALLIED HEALTH	2,105	864	0	261	0	23.01
23.02	02302	PHARMACY RESIDENCY-ALLIED HEALTH	136,914	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,684,845	4,890,558	531,148	1,477,758	1,586,010	30.00
31.00	03100	INTENSIVE CARE UNIT	1,356,279	597,351	83,001	180,499	158,175	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,061,728	1,125,943	30,311	340,221	351,319	35.00
40.00	04000	SUBPROVIDER - I PF	425,229	310,274	0	93,754	95,622	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
43.00	04300	NURSERY	800,383	568,913	39,645	171,906	240,925	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,609,622	869,789	49,529	262,820	0	50.00
51.00	05100	RECOVERY ROOM	746,278	361,181	0	109,137	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,274,064	1,534,412	106,930	463,647	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,488,190	317,458	65,627	95,925	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	280,457	219,939	7,849	66,458	0	55.00
57.00	05700	CT SCAN	471,049	39,996	0	12,085	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,207,762	145,293	0	43,903	0	58.00
60.00	06000	LABORATORY	1,047,961	161,875	0	48,913	0	60.00
64.00	06400	INTRAVENOUS THERAPY	106,599	5,428	0	1,640	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,034,845	175,108	0	52,912	0	65.00
66.00	06600	PHYSICAL THERAPY	1,529,102	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	418,493	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	95,457	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	400,935	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	437,507	42,751	0	12,918	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,816,767	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,772,858	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,784,557	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	174,247	5,347	0	1,616	0	74.00
76.00	03330	ENDOSCOPY	480,150	225,853	21,499	68,245	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0	0	76.05
76.06	03954	IMAGING CENTER	1,003,303	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	1,494,976	0	0	0	0	76.07
76.08	03956	BARIATRIC CLINIC	2,835	0	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0	0	90.24
90.26	04975	SPINE CENTER	59,881	0	2,049	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0	0	90.27
91.00	09100	EMERGENCY	2,409,614	885,561	164,885	267,586	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,550,036	14,099,730	1,102,473	4,205,298	2,432,051	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,290	93,982	0	28,398	0	190.00
191.00	19100	RESEARCH	6,559	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,188,403	23,982	0	7,246	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	13,229	120,826	0	36,509	0	194.00
194.06	07956	PAVILLIONS	543,615	0	0	0	0	194.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
194.07	07957	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08	07958	OTHER NONREIMBURSABLE COST CENTERS	369,652	0	0	0	0	194.08
194.09	07959	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07960	COMMUNITY REHAB HOSPITAL	105,725	0	0	0	0	194.10
194.11	07961	WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
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)	54,787,509	14,338,520	1,102,473	4,277,451	2,432,051	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part I Date/Time Prepared: 5/27/2015 6:07 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,744,336					11.00
13.00	01300	37,484	3,484,085				13.00
14.00	01400	0	0	2,828,679			14.00
15.00	01500	99,064	0	631,575	4,969,548		15.00
16.00	01600	16,064	0	10	0	4,306,900	16.00
17.00	01700	66,935	0	599	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
23.02	02302	8,032	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	891,575	1,862,279	135,092	208	481,783	30.00
31.00	03100	133,870	279,622	30,331	99	71,233	31.00
35.00	02060	192,773	402,655	22,030	23	293,672	35.00
40.00	04000	42,838	89,479	2,567	0	23,915	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	74,967	0	18,308	0	40,005	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	195,450	357,916	1,513,464	222	495,848	50.00
51.00	05100	77,645	0	20,043	0	102,575	51.00
52.00	05200	198,128	0	49,379	0	107,898	52.00
54.00	05400	115,128	0	34,515	51,055	139,794	54.00
55.00	05500	13,387	0	68,290	0	61,790	55.00
57.00	05700	32,129	0	15,503	0	227,211	57.00
58.00	05800	24,097	0	8,855	0	107,843	58.00
60.00	06000	0	0	91,402	0	355,332	60.00
64.00	06400	10,710	0	6,684	0	5,609	64.00
65.00	06500	109,773	0	31,005	2,066	116,310	65.00
66.00	06600	45,516	0	5,492	405	86,926	66.00
67.00	06700	34,806	0	1,743	0	18,471	67.00
68.00	06800	8,032	0	398	0	6,324	68.00
69.00	06900	2,677	0	44	0	25,703	69.00
70.00	07000	32,129	0	6,743	0	32,142	70.00
71.00	07100	0	0	0	0	253,346	71.00
72.00	07200	0	0	0	0	181,267	72.00
73.00	07300	0	0	0	4,905,439	307,199	73.00
74.00	07400	0	0	710	0	8,176	74.00
76.00	03330	34,806	0	46,652	0	52,188	76.00
76.01	03550	0	0	0	0	0	76.01
76.02	03950	0	0	0	0	0	76.02
76.03	03951	0	0	0	0	0	76.03
76.04	03952	0	0	0	0	0	76.04
76.05	03953	0	0	0	0	0	76.05
76.06	03954	0	0	19,148	117	191,389	76.06
76.07	03955	0	0	1,344	0	44,640	76.07
76.08	03956	0	0	256	46	278	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.24	04973	0	0	0	0	0	90.24
90.26	04975	0	0	683	4,443	3,009	90.26
90.27	04976	0	0	0	0	0	90.27
91.00	09100	235,611	492,134	57,268	184	465,024	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,733,626	3,484,085	2,820,133	4,964,307	4,306,900	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	4,438	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part I
Date/Time Prepared:
5/27/2015 6:07 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
194.06	07956 PAVILLIONS	0	0	68	0	0	194.06
194.07	07957 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08	07958 OTHER NONREIMBURSABLE COST CENTERS	0	0	3,376	0	0	194.08
194.09	07959 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07960 COMMUNITY REHAB HOSPITAL	10,710	0	664	5,241	0	194.10
194.11	07961 WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
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)	2,744,336	3,484,085	2,828,679	4,969,548	4,306,900	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part I
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Line	Code	Cost Center Description	INTERNS & RESIDENTS				EMS TRAINING PROGRAM-ALLIED HEALTH	23.00
			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
					21.00	22.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	3,827,814					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		0				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		0	138,953			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0	0	237,348		22.00
23.00	02300	EMS TRAINING PROGRAM-ALLIED HEALTH		0	0	0	157,280	23.00
23.01	02301	RADIOLOGY SCHOOL-ALLIED HEALTH		0	0	0	0	23.01
23.02	02302	PHARMACY RESIDENCY-ALLIED HEALTH		0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,496,226	0	111,875	191,095	0	30.00
31.00	03100	INTENSIVE CARE UNIT	248,952	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	552,943	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - I/PF	150,500	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0	41.00
43.00	04300	NURSERY	379,193	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0	0	76.05
76.06	03954	IMAGING CENTER	0	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
76.08	03956	BARITRIC CLINIC	0	0	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0	0	90.24
90.26	04975	SPINE CENTER	0	0	0	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0	0	90.27
91.00	09100	EMERGENCY	0	0	27,078	46,253	157,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,827,814	0	138,953	237,348	157,280	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part I
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Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		EMS TRAINING PROGRAM-ALLIED HEALTHEM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.00	19.00		
193.00 19300 NONPAID WORKERS	0	0	0	0	0	0 193.00
194.00 07950 HOME OFFICE	0	0	0	0	0	0 194.00
194.06 07956 PAVILLIONS	0	0	0	0	0	0 194.06
194.07 07957 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0 194.07
194.08 07958 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0 194.08
194.09 07959 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0 194.09
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	0 194.10
194.11 07961 WALGREENS TAKE CARE CLINIC	0	0	0	0	0	0 194.11
200.00 Cross Foot Adjustments		0	0	0	0	0 200.00
201.00 Negative Cost Centers	0	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	3,827,814	0	138,953	237,348	157,280	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part I
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Cost Center Description			RADIOLOGY SCHOOL-ALLIED HEALTH	PHARMACY RESIDENCY-ALLI ED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.01	23.02	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	EMS TRAINING PROGRAM-ALLIED HEALTHEM						23.00
23.01	02301	RADIOLOGY SCHOOL-ALLIED HEALTH	11,006					23.01
23.02	02302	PHARMACY RESIDENCY-ALLIED HEALTH	0	650,763				23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	50,731,590	-302,970	50,428,620	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	8,150,065	0	8,150,065	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	12,990,494	0	12,990,494	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,805,150	0	2,805,150	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	5,291,190	0	5,291,190	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	20,690,094	0	20,690,094	50.00
51.00	05100	RECOVERY ROOM	0	0	4,173,917	0	4,173,917	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	13,135,788	0	13,135,788	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,006	0	7,816,686	0	7,816,686	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	1,754,295	0	1,754,295	55.00
57.00	05700	CT SCAN	0	0	2,538,223	0	2,538,223	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	5,999,724	0	5,999,724	58.00
60.00	06000	LABORATORY	0	0	5,577,085	0	5,577,085	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	530,491	0	530,491	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	5,345,164	0	5,345,164	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,316,575	0	7,316,575	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,019,600	0	2,019,600	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	462,870	0	462,870	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,910,579	0	1,910,579	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,180,520	0	2,180,520	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	13,476,415	0	13,476,415	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,892,620	0	17,892,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	650,763	18,935,261	0	18,935,261	73.00
74.00	07400	RENAL DIALYSIS	0	0	833,838	0	833,838	74.00
76.00	03330	ENDOSCOPY	0	0	2,703,266	0	2,703,266	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0	0	76.05
76.06	03954	IMAGING CENTER	0	0	4,920,572	0	4,920,572	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	7,064,019	0	7,064,019	76.07
76.08	03956	BARITRIC CLINIC	0	0	13,888	0	13,888	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0	0	90.24
90.26	04975	SPINE CENTER	0	0	291,290	0	291,290	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0	0	90.27
91.00	09100	EMERGENCY	0	0	14,110,588	-73,331	14,037,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,006	650,763	241,661,857	-376,301	241,285,556	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	170,685	0	170,685	190.00
191.00	19100	RESEARCH	0	0	30,792	0	30,792	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	10,308,933	0	10,308,933	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

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Cost Center Description		RADIOLOGY SCHOOL-ALLIED HEALTH	PHARMACY RESIDENCY-ALLI ED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.01	23.02	24.00	25.00	26.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	219,437	0	194.00
194.06	07956	PAVILLIONS	0	0	2,552,023	0	194.06
194.07	07957	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.07
194.08	07958	OTHER NONREIMBURSABLE COST CENTERS	0	0	1,738,674	0	194.08
194.09	07959	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.09
194.10	07960	COMMUNITY REHAB HOSPITAL	0	0	512,933	0	194.10
194.11	07961	WALGREENS TAKE CARE CLINIC	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,006	650,763	257,195,334	-376,301	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/27/2015 6:07 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,180	17,664	29,844	29,844 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	866,505	10,896,367	11,762,872	3,756 5.00
7.00 00700	OPERATION OF PLANT	0	1,027,490	99,073	1,126,563	796 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	26,469	0	26,469	0 8.00
9.00 00900	HOUSEKEEPING	0	47,366	9,545	56,911	640 9.00
10.00 01000	DIETARY	0	93,334	25,001	118,335	353 10.00
11.00 01100	CAFETERIA	0	153,186	41,035	194,221	404 11.00
13.00 01300	NURSING ADMINISTRATION	0	41,882	849	42,731	171 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	172,051	69,401	241,452	0 14.00
15.00 01500	PHARMACY	0	82,366	148,011	230,377	1,020 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	10,356	0	10,356	153 16.00
17.00 01700	SOCIAL SERVICE	0	17,260	0	17,260	606 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
23.00 02300	EMS TRAINING PROGRAM-ALLIED HEALTHEM	0	9,329	0	9,329	8 23.00
23.01 02301	RADIOLOGY SCHOOL-ALLIED HEALTH	0	350	0	350	2 23.01
23.02 02302	PHARMACY RESIDENCY-ALLIED HEALTH	0	0	0	0	67 23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,978,205	539,612	2,517,817	6,762 30.00
31.00 03100	INTENSIVE CARE UNIT	0	241,625	31,143	272,768	1,103 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	455,439	190,942	646,381	1,707 35.00
40.00 04000	SUBPROVIDER - I PF	0	125,505	17,796	143,301	365 40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00
43.00 04300	NURSERY	0	230,123	47,598	277,721	603 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	351,826	1,540,750	1,892,576	1,614 50.00
51.00 05100	RECOVERY ROOM	0	146,096	22,182	168,278	654 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	620,663	128,377	749,040	1,626 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	128,410	759,360	887,770	1,008 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	88,964	147,174	236,138	121 55.00
57.00 05700	CT SCAN	0	16,178	49,117	65,295	286 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58,771	591,019	649,790	216 58.00
60.00 06000	LABORATORY	0	65,478	1,076	66,554	0 60.00
64.00 06400	INTRAVENOUS THERAPY	0	2,196	2,984	5,180	98 64.00
65.00 06500	RESPIRATORY THERAPY	0	70,830	144,464	215,294	899 65.00
66.00 06600	PHYSICAL THERAPY	0	0	71,354	71,354	1,007 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	22,643	22,643	321 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	5,165	5,165	73 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	17,626	17,626	11 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	17,293	89,026	106,319	256 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	2,163	0	2,163	0 74.00
76.00 03330	ENDOSCOPY	0	91,356	254,275	345,631	301 76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.01
76.02 03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	0 76.02
76.03 03951	OTHER ANCILLARY SERVICES	0	0	0	0	0 76.03
76.04 03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.04
76.05 03953	MISC ANCILLARY	0	0	0	0	0 76.05
76.06 03954	IMAGING CENTER	0	0	668,472	668,472	419 76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	62,820	62,820	0 76.07
76.08 03956	BIOPSY CLINIC	0	0	0	0	1 76.08
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.24 04973	PALLIATIVE CARE	0	0	0	0	0 90.24
90.26 04975	SPINE CENTER	0	0	0	0	59 90.26
90.27 04976	DIABETIC CARE CENTER	0	0	0	0	0 90.27
91.00 09100	EMERGENCY	0	358,205	55,970	414,175	1,883 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	7,609,450	16,767,891	24,377,341	29,369 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,015	0	38,015	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	9,700	0	9,700	294	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 HOME OFFICE	0	48,873	0	48,873	0	194.00
194.06 07956 PAVILLIONS	0	0	429,366	429,366	0	194.06
194.07 07957 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08 07958 OTHER NONREIMBURSABLE COST CENTERS	0	0	7,712	7,712	79	194.08
194.09 07959 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	102	194.10
194.11 07961 WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 TOTAL (sum lines 118-201)	0	7,706,038	17,204,969	24,911,007	29,844	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/27/2015 6:07 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	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	11,766,628				5.00	
7.00	00700	OPERATION OF PLANT	655,981	1,783,340			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	47,444	8,139	82,052		8.00	
9.00	00900	HOUSEKEEPING	190,334	14,564	0	262,449	9.00	
10.00	01000	DIETARY	97,519	28,698	0	4,278	249,183	10.00
11.00	01100	CAFETERIA	102,991	47,101	0	7,021	0	11.00
13.00	01300	NURSING ADMINISTRATION	151,512	12,878	0	1,920	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,071	52,902	0	7,886	0	14.00
15.00	01500	PHARMACY	181,797	25,326	0	3,775	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	194,778	3,184	0	475	0	16.00
17.00	01700	SOCIAL SERVICE	169,489	5,307	0	791	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	6,357	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	10,859	0	0	0	0	22.00
23.00	02300	EMS TRAINING PROGRAM-ALLIED HEALTHEM	5,822	2,868	0	428	0	23.00
23.01	02301	RADIOLOGY SCHOOL-ALLIED HEALTH	452	107	0	16	0	23.01
23.02	02302	PHARMACY RESIDENCY-ALLIED HEALTH	29,405	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,650,514	608,259	39,532	90,667	162,500	30.00
31.00	03100	INTENSIVE CARE UNIT	291,284	74,295	6,177	11,075	16,206	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	442,792	140,038	2,256	20,875	35,995	35.00
40.00	04000	SUBPROVIDER - I/PF	91,325	38,590	0	5,752	9,797	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0	41.00
43.00	04300	NURSERY	171,896	70,758	2,951	10,548	24,685	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	775,229	108,179	3,686	16,126	0	50.00
51.00	05100	RECOVERY ROOM	160,276	44,922	0	6,696	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	488,395	190,841	7,958	28,448	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	319,615	39,484	4,884	5,886	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	60,233	27,355	584	4,078	0	55.00
57.00	05700	CT SCAN	101,166	4,974	0	742	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	259,388	18,071	0	2,694	0	58.00
60.00	06000	LABORATORY	225,068	20,133	0	3,001	0	60.00
64.00	06400	INTRAVENOUS THERAPY	22,894	675	0	101	0	64.00
65.00	06500	RESPIRATORY THERAPY	222,251	21,779	0	3,246	0	65.00
66.00	06600	PHYSICAL THERAPY	328,401	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,879	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,501	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	86,108	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93,962	5,317	0	793	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	604,950	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	810,287	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	598,032	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	37,423	665	0	99	0	74.00
76.00	03330	ENDOSCOPY	103,121	28,090	1,600	4,187	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0	0	76.05
76.06	03954	IMAGING CENTER	215,477	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	321,072	0	0	0	0	76.07
76.08	03956	BARIATRIC CLINIC	609	0	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0	0	90.24
90.26	04975	SPINE CENTER	12,860	0	152	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0	0	90.27
91.00	09100	EMERGENCY	517,506	110,141	12,272	16,418	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,071,325	1,753,640	82,052	258,022	249,183	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,210	11,689	0	1,742	0	190.00
191.00	19100	RESEARCH	1,409	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	469,997	2,983	0	445	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	2,841	15,028	0	2,240	0	194.00
194.06	07956	PAVILLIONS	116,751	0	0	0	0	194.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
194.07	07957	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08	07958	OTHER NONREIMBURSABLE COST CENTERS	79,389	0	0	0	0	194.08
194.09	07959	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07960	COMMUNITY REHAB HOSPITAL	22,706	0	0	0	0	194.10
194.11	07961	WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
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)	11,766,628	1,783,340	82,052	262,449	249,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/27/2015 6:07 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	351,738					11.00
13.00	01300	4,804	214,016				13.00
14.00	01400	0	0	406,311			14.00
15.00	01500	12,697	0	90,719	545,711		15.00
16.00	01600	2,059	0	1	0	211,006	16.00
17.00	01700	8,579	0	86	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
23.02	02302	1,029	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	114,271	114,394	19,405	23	23,567	30.00
31.00	03100	17,158	17,176	4,357	11	3,485	31.00
35.00	02060	24,707	24,734	3,164	7	14,366	35.00
40.00	04000	5,491	5,496	369	0	1,170	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	9,608	0	2,630	0	1,957	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	25,051	21,986	217,395	24	24,580	50.00
51.00	05100	9,952	0	2,879	0	5,018	51.00
52.00	05200	25,394	0	7,093	0	5,278	52.00
54.00	05400	14,756	0	4,958	5,606	6,838	54.00
55.00	05500	1,716	0	9,809	0	3,023	55.00
57.00	05700	4,118	0	2,227	0	11,114	57.00
58.00	05800	3,088	0	1,272	0	5,275	58.00
60.00	06000	0	0	13,129	0	17,382	60.00
64.00	06400	1,373	0	960	0	274	64.00
65.00	06500	14,070	0	4,453	227	5,690	65.00
66.00	06600	5,834	0	789	45	4,252	66.00
67.00	06700	4,461	0	250	0	904	67.00
68.00	06800	1,029	0	57	0	309	68.00
69.00	06900	343	0	6	0	1,257	69.00
70.00	07000	4,118	0	969	0	1,572	70.00
71.00	07100	0	0	0	0	12,393	71.00
72.00	07200	0	0	0	0	8,867	72.00
73.00	07300	0	0	0	538,670	15,027	73.00
74.00	07400	0	0	102	0	400	74.00
76.00	03330	4,461	0	6,701	0	2,553	76.00
76.01	03550	0	0	0	0	0	76.01
76.02	03950	0	0	0	0	0	76.02
76.03	03951	0	0	0	0	0	76.03
76.04	03952	0	0	0	0	0	76.04
76.05	03953	0	0	0	0	0	76.05
76.06	03954	0	0	2,750	13	9,362	76.06
76.07	03955	0	0	193	0	2,184	76.07
76.08	03956	0	0	37	5	14	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.24	04973	0	0	0	0	0	90.24
90.26	04975	0	0	98	488	147	90.26
90.27	04976	0	0	0	0	0	90.27
91.00	09100	30,198	30,230	8,226	20	22,748	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		350,365	214,016	405,084	545,135	211,006	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	637	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150169

Period:
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
194.06 07956 PAVILLIONS	0	0	10	0	0	194.06
194.07 07957 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08 07958 OTHER NONREIMBURSABLE COST CENTERS	0	0	485	0	0	194.08
194.09 07959 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10 07960 COMMUNITY REHAB HOSPITAL	1,373	0	95	576	0	194.10
194.11 07961 WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
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)	351,738	214,016	406,311	545,711	211,006	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B
Part II
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Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		EMS TRAINING PROGRAM-ALLIED HEALTH	HEALTH
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.00	19.00		
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500						15.00
16.00 01600						16.00
17.00 01700	202,118					17.00
19.00 01900		0	0			19.00
21.00 02100		0	6,357			21.00
22.00 02200		0		10,859		22.00
23.00 02300		0			18,455	23.00
23.01 02301		0				23.01
23.02 02302		0				23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	131,807					30.00
31.00 03100	13,145					31.00
35.00 02060	29,197					35.00
40.00 04000	7,947					40.00
41.00 04100	0					41.00
43.00 04300	20,022					43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0					50.00
51.00 05100	0					51.00
52.00 05200	0					52.00
54.00 05400	0					54.00
55.00 05500	0					55.00
57.00 05700	0					57.00
58.00 05800	0					58.00
60.00 06000	0					60.00
64.00 06400	0					64.00
65.00 06500	0					65.00
66.00 06600	0					66.00
67.00 06700	0					67.00
68.00 06800	0					68.00
69.00 06900	0					69.00
70.00 07000	0					70.00
71.00 07100	0					71.00
72.00 07200	0					72.00
73.00 07300	0					73.00
74.00 07400	0					74.00
76.00 03330	0					76.00
76.01 03550	0					76.01
76.02 03950	0					76.02
76.03 03951	0					76.03
76.04 03952	0					76.04
76.05 03953	0					76.05
76.06 03954	0					76.06
76.07 03955	0					76.07
76.08 03956	0					76.08
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	0					90.00
90.24 04973	0					90.24
90.26 04975	0					90.26
90.27 04976	0					90.27
91.00 09100	0					91.00
92.00 09200	0					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300						113.00
118.00	202,118	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	0					190.00
191.00 19100	0					191.00
192.00 19200	0					192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150169

Period:
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Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		EMS TRAINING PROGRAM-ALLIED HEALTH	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			17.00	19.00		
193.00 19300 NONPAID WORKERS	0					193.00
194.00 07950 HOME OFFICE	0					194.00
194.06 07956 PAVILLIONS	0					194.06
194.07 07957 OTHER NONREIMBURSABLE COST CENTERS	0					194.07
194.08 07958 OTHER NONREIMBURSABLE COST CENTERS	0					194.08
194.09 07959 OTHER NONREIMBURSABLE COST CENTERS	0					194.09
194.10 07960 COMMUNITY REHAB HOSPITAL	0					194.10
194.11 07961 WALGREENS TAKE CARE CLINIC	0					194.11
200.00 Cross Foot Adjustments		0	6,357	10,859	18,455	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	202,118	0	6,357	10,859	18,455	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/27/2015 6:07 pm		
Cost Center Description			RADIOLOGY SCHOOL-ALLIED HEALTH	PHARMACY RESIDENCY-ALLI ED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			23.01	23.02	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	EMS TRAINING PROGRAM-ALLIED HEALTH					23.00
23.01	02301	RADIOLOGY SCHOOL-ALLIED HEALTH	927				23.01
23.02	02302	PHARMACY RESIDENCY-ALLIED HEALTH		30,501			23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS			5,479,518	0	30.00
31.00	03100	INTENSIVE CARE UNIT			728,240	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			1,386,215	0	35.00
40.00	04000	SUBPROVIDER - IPF			309,603	0	40.00
41.00	04100	SUBPROVIDER - IRF			0	0	41.00
43.00	04300	NURSERY			593,379	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM			3,086,446	0	50.00
51.00	05100	RECOVERY ROOM			398,675	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			1,504,073	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			1,290,805	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC			343,057	0	55.00
57.00	05700	CT SCAN			189,922	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)			939,794	0	58.00
60.00	06000	LABORATORY			345,267	0	60.00
64.00	06400	INTRAVENOUS THERAPY			31,555	0	64.00
65.00	06500	RESPIRATORY THERAPY			487,909	0	65.00
66.00	06600	PHYSICAL THERAPY			411,682	0	66.00
67.00	06700	OCCUPATIONAL THERAPY			118,458	0	67.00
68.00	06800	SPEECH PATHOLOGY			27,134	0	68.00
69.00	06900	ELECTROCARDIOLOGY			105,351	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			213,306	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS			617,343	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			819,154	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			1,151,729	0	73.00
74.00	07400	RENAL DIALYSIS			40,852	0	74.00
76.00	03330	ENDOSCOPY			496,645	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES			0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES			0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES			0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS			0	0	76.04
76.05	03953	MISC ANCILLARY			0	0	76.05
76.06	03954	IMAGING CENTER			896,493	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER			386,269	0	76.07
76.08	03956	BARITRIC CLINIC			666	0	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC			0	0	90.00
90.24	04973	PALLIATIVE CARE			0	0	90.24
90.26	04975	SPINE CENTER			13,804	0	90.26
90.27	04976	DIABETIC CARE CENTER			0	0	90.27
91.00	09100	EMERGENCY			1,163,817	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	23,577,161	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			53,656	0	190.00
191.00	19100	RESEARCH			1,409	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			484,056	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/27/2015 6:07 pm	
Cost Center Description			RADIOLOGY SCHOOL-ALLIED HEALTH	PHARMACY RESIDENCY-ALLI ED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.01	23.02	24.00	25.00	26.00	
193.00	19300	NONPAID WORKERS			0	0	0	193.00
194.00	07950	HOME OFFICE			68,982	0	68,982	194.00
194.06	07956	PAVILLIONS			546,127	0	546,127	194.06
194.07	07957	OTHER NONREIMBURSABLE COST CENTERS			0	0	0	194.07
194.08	07958	OTHER NONREIMBURSABLE COST CENTERS			87,665	0	87,665	194.08
194.09	07959	OTHER NONREIMBURSABLE COST CENTERS			0	0	0	194.09
194.10	07960	COMMUNITY REHAB HOSPITAL			24,852	0	24,852	194.10
194.11	07961	WALGREENS TAKE CARE CLINIC			0	0	0	194.11
200.00		Cross Foot Adjustments	927	30,501	67,099	0	67,099	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	927	30,501	24,911,007	0	24,911,007	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1

Date/Time Prepared:
5/27/2015 6:07 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	705,430				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		17,296,112			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,115	17,758	88,732,743		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	79,322	10,954,086	11,179,144	-54,787,509	5.00
7.00 00700	OPERATION OF PLANT	94,059	99,598	2,368,377	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,423	0	0	0	8.00
9.00 00900	HOUSEKEEPING	4,336	9,596	1,904,868	0	9.00
10.00 01000	DIETARY	8,544	25,133	1,050,942	0	10.00
11.00 01100	CAFETERIA	14,023	41,252	1,202,971	0	11.00
13.00 01300	NURSING ADMINISTRATION	3,834	853	509,206	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	15,750	69,769	0	0	14.00
15.00 01500	PHARMACY	7,540	148,795	3,035,577	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	948	0	455,963	0	16.00
17.00 01700	SOCIAL SERVICE	1,580	0	1,804,029	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	EMS TRAINING PROGRAM-ALLIED HEALTHEM	854	0	22,936	0	23.00
23.01 02301	RADIOLOGY SCHOOL-ALLIED HEALTH	32	0	5,915	0	23.01
23.02 02302	PHARMACY RESIDENCY-ALLIED HEALTH	0	0	200,245	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	181,090	542,471	20,035,467	0	30.00
31.00 03100	INTENSIVE CARE UNIT	22,119	31,308	3,282,787	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	41,692	191,954	5,079,906	0	35.00
40.00 04000	SUBPROVIDER - I PF	11,489	17,890	1,087,484	0	40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	41.00
43.00 04300	NURSERY	21,066	47,850	1,794,047	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,207	1,548,913	4,803,650	0	50.00
51.00 05100	RECOVERY ROOM	13,374	22,300	1,945,478	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	56,817	129,057	4,838,740	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,755	763,383	3,000,754	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	8,144	147,954	359,736	0	55.00
57.00 05700	CT SCAN	1,481	49,377	851,563	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	5,380	594,150	641,774	0	58.00
60.00 06000	LABORATORY	5,994	1,082	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	201	3,000	290,956	0	64.00
65.00 06500	RESPIRATORY THERAPY	6,484	145,229	2,676,901	0	65.00
66.00 06600	PHYSICAL THERAPY	0	71,732	2,996,575	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	22,763	955,078	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	5,192	217,851	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	17,719	31,719	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,583	89,498	761,943	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	198	0	0	0	74.00
76.00 03330	ENDOSCOPY	8,363	255,622	895,295	0	76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.02 03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	76.02
76.03 03951	OTHER ANCILLARY SERVICES	0	0	0	0	76.03
76.04 03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.04
76.05 03953	MISC ANCILLARY	0	0	0	0	76.05
76.06 03954	IMAGING CENTER	0	672,014	1,247,781	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	63,153	0	0	76.07
76.08 03956	BARIATRIC CLINIC	0	0	3,992	0	76.08
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.24 04973	PALLIATIVE CARE	0	0	0	0	90.24
90.26 04975	SPIRE CENTER	0	0	175,739	0	90.26
90.27 04976	DIABETIC CARE CENTER	0	0	0	0	90.27
91.00 09100	EMERGENCY	32,791	56,267	5,605,071	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	696,588	16,856,718	87,320,460	-54,787,509	190,447,261
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,480	0	0	0	38,015

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1

Date/Time Prepared:
5/27/2015 6:07 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
191.00 19100 RESEARCH	0	0	0	0	24,233	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	888	0	876,328	0	8,084,864	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 HOME OFFICE	4,474	0	0	0	48,873	194.00
194.06 07956 PAVILIONS	0	431,641	0	0	2,008,340	194.06
194.07 07957 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08 07958 OTHER NONREIMBURSABLE COST CENTERS	0	7,753	233,815	0	1,365,646	194.08
194.09 07959 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	302,140	0	390,593	194.10
194.11 07961 WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
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)	7,706,038	17,204,969	15,866,617		54,787,509	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10.923888	0.994730	0.178814		0.270679	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			29,844		11,766,628	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000336		0.058133	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	530,934					7.00
8.00	00800	2,423	242,713				8.00
9.00	00900	4,336	0	524,175			9.00
10.00	01000	8,544	0	8,544	79,354		10.00
11.00	01100	14,023	0	14,023	0	1,025	11.00
13.00	01300	3,834	0	3,834	0	14	13.00
14.00	01400	15,750	0	15,750	0	0	14.00
15.00	01500	7,540	0	7,540	0	37	15.00
16.00	01600	948	0	948	0	6	16.00
17.00	01700	1,580	0	1,580	0	25	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	854	0	854	0	0	23.00
23.01	02301	32	0	32	0	0	23.01
23.02	02302	0	0	0	0	3	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	181,090	116,934	181,090	51,749	333	30.00
31.00	03100	22,119	18,273	22,119	5,161	50	31.00
35.00	02060	41,692	6,673	41,692	11,463	72	35.00
40.00	04000	11,489	0	11,489	3,120	16	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	21,066	8,728	21,066	7,861	28	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	32,207	10,904	32,207	0	73	50.00
51.00	05100	13,374	0	13,374	0	29	51.00
52.00	05200	56,817	23,541	56,817	0	74	52.00
54.00	05400	11,755	14,448	11,755	0	43	54.00
55.00	05500	8,144	1,728	8,144	0	5	55.00
57.00	05700	1,481	0	1,481	0	12	57.00
58.00	05800	5,380	0	5,380	0	9	58.00
60.00	06000	5,994	0	5,994	0	0	60.00
64.00	06400	201	0	201	0	4	64.00
65.00	06500	6,484	0	6,484	0	41	65.00
66.00	06600	0	0	0	0	17	66.00
67.00	06700	0	0	0	0	13	67.00
68.00	06800	0	0	0	0	3	68.00
69.00	06900	0	0	0	0	1	69.00
70.00	07000	1,583	0	1,583	0	12	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	198	0	198	0	0	74.00
76.00	03330	8,363	4,733	8,363	0	13	76.00
76.01	03550	0	0	0	0	0	76.01
76.02	03950	0	0	0	0	0	76.02
76.03	03951	0	0	0	0	0	76.03
76.04	03952	0	0	0	0	0	76.04
76.05	03953	0	0	0	0	0	76.05
76.06	03954	0	0	0	0	0	76.06
76.07	03955	0	0	0	0	0	76.07
76.08	03956	0	0	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.24	04973	0	0	0	0	0	90.24
90.26	04975	0	451	0	0	0	90.26
90.27	04976	0	0	0	0	0	90.27
91.00	09100	32,791	36,300	32,791	0	88	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		522,092	242,713	515,333	79,354	1,021	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	3,480	0	3,480	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	888	0	888	0	0	192.00
193.00	19300	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
194.00	07950 HOME OFFICE	4,474	0	4,474	0	0	194.00
194.06	07956 PAVILLIONS	0	0	0	0	0	194.06
194.07	07957 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08	07958 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.08
194.09	07959 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	4	194.10
194.11	07961 WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
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)	14,338,520	1,102,473	4,277,451	2,432,051	2,744,336	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	27.006219	4.542291	8.160349	30.648121	2,677.400976	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,783,340	82,052	262,449	249,183	351,738	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.358873	0.338062	0.500690	3.140144	343.159024	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1
Date/Time Prepared:
5/27/2015 6:07 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	623					13.00
14.00	01400	0	46,203,048				14.00
15.00	01500	0	10,315,969	10,286,953			15.00
16.00	01600	0	168	0	1,048,287,429		16.00
17.00	01700	0	9,788	0	0	79,354	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
23.02	02302	0	0	0	0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	333	2,206,563	430	117,250,663	51,749	30.00
31.00	03100	50	495,426	205	17,335,927	5,161	31.00
35.00	02060	72	359,827	48	71,470,515	11,463	35.00
40.00	04000	16	41,930	0	5,820,250	3,120	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	0	299,038	0	9,735,925	7,861	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	64	24,720,711	459	120,798,125	0	50.00
51.00	05100	0	327,372	0	24,963,444	0	51.00
52.00	05200	0	806,539	0	26,258,849	0	52.00
54.00	05400	0	563,759	105,684	34,021,391	0	54.00
55.00	05500	0	1,115,425	0	15,037,761	0	55.00
57.00	05700	0	253,218	0	55,295,989	0	57.00
58.00	05800	0	144,631	0	26,245,650	0	58.00
60.00	06000	0	1,492,937	0	86,476,587	0	60.00
64.00	06400	0	109,176	0	1,364,945	0	64.00
65.00	06500	0	506,421	4,276	28,306,065	0	65.00
66.00	06600	0	89,698	839	21,154,971	0	66.00
67.00	06700	0	28,465	0	4,495,255	0	67.00
68.00	06800	0	6,493	0	1,538,973	0	68.00
69.00	06900	0	717	0	6,255,328	0	69.00
70.00	07000	0	110,141	0	7,822,372	0	70.00
71.00	07100	0	0	0	61,656,352	0	71.00
72.00	07200	0	0	0	44,114,734	0	72.00
73.00	07300	0	0	10,154,247	74,762,550	0	73.00
74.00	07400	0	11,597	0	1,989,829	0	74.00
76.00	03330	0	762,009	0	12,700,946	0	76.00
76.01	03550	0	0	0	0	0	76.01
76.02	03950	0	0	0	0	0	76.02
76.03	03951	0	0	0	0	0	76.03
76.04	03952	0	0	0	0	0	76.04
76.05	03953	0	0	0	0	0	76.05
76.06	03954	0	312,761	243	46,578,034	0	76.06
76.07	03955	0	21,955	0	10,863,967	0	76.07
76.08	03956	0	4,174	96	67,545	0	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.24	04973	0	0	0	0	0	90.24
90.26	04975	0	11,151	9,197	732,310	0	90.26
90.27	04976	0	0	0	0	0	90.27
91.00	09100	88	935,399	380	113,172,177	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		623	46,063,458	10,276,104	1,048,287,429	79,354	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	72,487	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
		13.00	14.00	15.00	16.00	17.00		
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	HOME OFFICE	0	0	0	0	0	194.00
194.06	07956	PAVILLIONS	0	1,112	0	0	0	194.06
194.07	07957	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.07
194.08	07958	OTHER NONREIMBURSABLE COST CENTERS	0	55,139	0	0	0	194.08
194.09	07959	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.09
194.10	07960	COMMUNITY REHAB HOSPITAL	0	10,852	10,849	0	0	194.10
194.11	07961	WALGREENS TAKE CARE CLINIC	0	0	0	0	0	194.11
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)	3,484,085	2,828,679	4,969,548	4,306,900	3,827,814	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5,592.431782	0.061223	0.483092	0.004109	48.237190	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	214,016	406,311	545,711	211,006	202,118	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	343.524880	0.008794	0.053049	0.000201	2.547042	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS					RADIOLOGY SCHOOL-ALLIED HEALTH (ASSIGNED TIME)	RADIOLOGY SCHOOL-ALLIED HEALTH (ASSIGNED TIME)
	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	EMS TRAINING PROGRAM-ALLIED HEALTHEM (ASSIGNED TIME)	RADIOLOGY SCHOOL-ALLIED HEALTH (ASSIGNED TIME)		
		19.00	21.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500	ADMINISTRATIVE & GENERAL						5.00
7.00 00700	OPERATION OF PLANT						7.00
8.00 00800	LAUNDRY & LINEN SERVICE						8.00
9.00 00900	HOUSEKEEPING						9.00
10.00 01000	DIETARY						10.00
11.00 01100	CAFETERIA						11.00
13.00 01300	NURSING ADMINISTRATION						13.00
14.00 01400	CENTRAL SERVICES & SUPPLY						14.00
15.00 01500	PHARMACY						15.00
16.00 01600	MEDICAL RECORDS & LIBRARY						16.00
17.00 01700	SOCIAL SERVICE						17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0					19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD		3,941				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			3,941			22.00
23.00 02300	EMS TRAINING PROGRAM-ALLIED HEALTHEM				100		23.00
23.01 02301	RADIOLOGY SCHOOL-ALLIED HEALTH				0	100	23.01
23.02 02302	PHARMACY RESIDENCY-ALLIED HEALTH				0	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS		3,173	3,173	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT		0	0	0	0	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT		0	0	0	0	35.00
40.00 04000	SUBPROVIDER - I PF		0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I RF		0	0	0	0	41.00
43.00 04300	NURSERY		0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	100	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000	LABORATORY	0	0	0	0	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03330	ENDOSCOPY	0	0	0	0	0	76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02 03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	0	76.02
76.03 03951	OTHER ANCILLARY SERVICES	0	0	0	0	0	76.03
76.04 03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.04
76.05 03953	MISC ANCILLARY	0	0	0	0	0	76.05
76.06 03954	IMAGING CENTER	0	0	0	0	0	76.06
76.07 03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76.07
76.08 03956	BARIATRIC CLINIC	0	0	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.24 04973	PALLIATIVE CARE	0	0	0	0	0	90.24
90.26 04975	SPINE CENTER	0	0	0	0	0	90.26
90.27 04976	DIABETIC CARE CENTER	0	0	0	0	0	90.27
91.00 09100	EMERGENCY	0	768	768	100	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,941	3,941	100	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet B-1

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Cost Center Description	INTERNS & RESIDENTS					
	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	EMS TRAINING PROGRAM-ALLIED HEALTH (ASSIGNED TIME)	RADIOLOGY SCHOOL-ALLIED HEALTH (ASSIGNED TIME)	
		19.00	21.00			
191.00 19100 RESEARCH	0	0	0	0	0	0 191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0 192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	0 193.00
194.00 07950 HOME OFFICE	0	0	0	0	0	0 194.00
194.06 07956 PAVILLIONS	0	0	0	0	0	0 194.06
194.07 07957 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0 194.07
194.08 07958 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0 194.08
194.09 07959 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0 194.09
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	0 194.10
194.11 07961 WALGREENS TAKE CARE CLINIC	0	0	0	0	0	0 194.11
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)	0	138,953	237,348	157,280	11,006	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	35.258310	60.225324	1,572.800000	110.060000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	6,357	10,859	18,455	927	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	1.613042	2.755392	184.550000	9.270000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150169

Period:
From 01/01/2014
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Cost Center Description		PHARMACY RESIDENCY-ALLIED HEALTH (ASSIGNED TIME)		
		23.02		
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	HOME OFFICE	0	194.00
194.06	07956	PAVILLIONS	0	194.06
194.07	07957	OTHER NONREIMBURSABLE COST CENTERS	0	194.07
194.08	07958	OTHER NONREIMBURSABLE COST CENTERS	0	194.08
194.09	07959	OTHER NONREIMBURSABLE COST CENTERS	0	194.09
194.10	07960	COMMUNITY REHAB HOSPITAL	0	194.10
194.11	07961	WALGREENS TAKE CARE CLINIC	0	194.11
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)	650,763	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6,507.630000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,501	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	305.010000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 6:07 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		50,428,620	0	50,428,620	30.00
31.00	03100 INTENSIVE CARE UNIT		8,150,065	0	8,150,065	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		12,990,494	0	12,990,494	35.00
40.00	04000 SUBPROVIDER - I/PF		2,805,150	0	2,805,150	40.00
41.00	04100 SUBPROVIDER - I/RF		0	0	0	41.00
43.00	04300 NURSERY		5,291,190	0	5,291,190	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		20,690,094	0	20,690,094	50.00
51.00	05100 RECOVERY ROOM		4,173,917	0	4,173,917	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		13,135,788	0	13,135,788	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,816,686	0	7,816,686	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		1,754,295	0	1,754,295	55.00
57.00	05700 CT SCAN		2,538,223	0	2,538,223	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		5,999,724	0	5,999,724	58.00
60.00	06000 LABORATORY		5,577,085	0	5,577,085	60.00
64.00	06400 INTRAVENOUS THERAPY		530,491	0	530,491	64.00
65.00	06500 RESPIRATORY THERAPY	0	5,345,164	0	5,345,164	65.00
66.00	06600 PHYSICAL THERAPY	0	7,316,575	0	7,316,575	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,019,600	0	2,019,600	67.00
68.00	06800 SPEECH PATHOLOGY	0	462,870	0	462,870	68.00
69.00	06900 ELECTROCARDIOLOGY		1,910,579	0	1,910,579	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		2,180,520	0	2,180,520	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		13,476,415	0	13,476,415	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		17,892,620	0	17,892,620	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		18,935,261	0	18,935,261	73.00
74.00	07400 RENAL DIALYSIS		833,838	0	833,838	74.00
76.00	03330 ENDOSCOPY		2,703,266	0	2,703,266	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES		0	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICES		0	0	0	76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS		0	0	0	76.04
76.05	03953 MISC ANCILLARY		0	0	0	76.05
76.06	03954 IMAGING CENTER		4,920,572	0	4,920,572	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER		7,064,019	0	7,064,019	76.07
76.08	03956 BARIATRIC CLINIC		13,888	0	13,888	76.08
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
90.24	04973 PALLIATIVE CARE		0	0	0	90.24
90.26	04975 SPINE CENTER		291,290	0	291,290	90.26
90.27	04976 DIABETIC CARE CENTER		0	0	0	90.27
91.00	09100 EMERGENCY		14,037,257	0	14,037,257	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		4,438,268	0	4,438,268	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		245,723,824	0	245,723,824	200.00
201.00	Less Observation Beds		4,438,268	0	4,438,268	201.00
202.00	Total (see instructions)		241,285,556	0	241,285,556	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/27/2015 6:07 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	94,440,486		94,440,486			30.00
31.00	03100	INTENSIVE CARE UNIT	17,335,927		17,335,927			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	71,470,515		71,470,515			35.00
40.00	04000	SUBPROVIDER - I/PF	5,820,250		5,820,250			40.00
41.00	04100	SUBPROVIDER - I/RF	0		0			41.00
43.00	04300	NURSERY	9,735,925		9,735,925			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	85,146,285	35,651,840	120,798,125	0.171278	0.000000	50.00
51.00	05100	RECOVERY ROOM	14,599,179	10,364,265	24,963,444	0.167201	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,258,849	0	26,258,849	0.500242	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,457,301	23,564,090	34,021,391	0.229758	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,431,059	8,606,702	15,037,761	0.116659	0.000000	55.00
57.00	05700	CT SCAN	18,919,757	36,376,232	55,295,989	0.045902	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,417,150	20,828,500	26,245,650	0.228599	0.000000	58.00
60.00	06000	LABORATORY	57,770,485	28,706,102	86,476,587	0.064492	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,206,908	158,037	1,364,945	0.388654	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	23,032,308	5,273,757	28,306,065	0.188835	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,084,051	16,070,920	21,154,971	0.345856	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,525,012	970,243	4,495,255	0.449274	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,020,654	518,319	1,538,973	0.300766	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,275,608	979,720	6,255,328	0.305432	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,025,446	6,796,926	7,822,372	0.278754	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,964,229	15,692,123	61,656,352	0.218573	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,414,305	5,700,429	44,114,734	0.405593	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,320,374	14,442,176	74,762,550	0.253272	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,989,829	0	1,989,829	0.419050	0.000000	74.00
76.00	03330	ENDOSCOPY	2,550,837	10,150,109	12,700,946	0.212840	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0.000000	0.000000	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.05
76.06	03954	IMAGING CENTER	287,123	46,290,911	46,578,034	0.105641	0.000000	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	22,808	10,841,159	10,863,967	0.650225	0.000000	76.07
76.08	03956	BIATRIC CLINIC	0	67,545	67,545	0.205611	0.000000	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0.000000	0.000000	90.24
90.26	04975	SPINE CENTER	0	732,310	732,310	0.397769	0.000000	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0.000000	0.000000	90.27
91.00	09100	EMERGENCY	26,266,790	86,905,387	113,172,177	0.124035	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,506,037	21,304,140	22,810,177	0.194574	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	641,295,487	406,991,942	1,048,287,429			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	641,295,487	406,991,942	1,048,287,429			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 6:07 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.171278		50.00
51.00	05100 RECOVERY ROOM	0.167201		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.500242		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.229758		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.116659		55.00
57.00	05700 CT SCAN	0.045902		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.228599		58.00
60.00	06000 LABORATORY	0.064492		60.00
64.00	06400 INTRAVENOUS THERAPY	0.388654		64.00
65.00	06500 RESPIRATORY THERAPY	0.188835		65.00
66.00	06600 PHYSICAL THERAPY	0.345856		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.449274		67.00
68.00	06800 SPEECH PATHOLOGY	0.300766		68.00
69.00	06900 ELECTROCARDIOLOGY	0.305432		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278754		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218573		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405593		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.253272		73.00
74.00	07400 RENAL DIALYSIS	0.419050		74.00
76.00	03330 ENDOSCOPY	0.212840		76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES	0.000000		76.02
76.03	03951 OTHER ANCILLARY SERVICES	0.000000		76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS	0.000000		76.04
76.05	03953 MISC ANCILLARY	0.000000		76.05
76.06	03954 IMAGING CENTER	0.105641		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.650225		76.07
76.08	03956 BARIATRIC CLINIC	0.205611		76.08
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
90.24	04973 PALLIATIVE CARE	0.000000		90.24
90.26	04975 SPINE CENTER	0.397769		90.26
90.27	04976 DIABETIC CARE CENTER	0.000000		90.27
91.00	09100 EMERGENCY	0.124035		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.194574		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
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: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 6:07 pm	
			Title XIX	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		50,428,620	0	50,428,620	30.00
31.00	03100 INTENSIVE CARE UNIT		8,150,065	0	8,150,065	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		12,990,494	0	12,990,494	35.00
40.00	04000 SUBPROVIDER - I/PF		2,805,150	0	2,805,150	40.00
41.00	04100 SUBPROVIDER - I/RF		0	0	0	41.00
43.00	04300 NURSERY		5,291,190	0	5,291,190	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		20,690,094	0	20,690,094	50.00
51.00	05100 RECOVERY ROOM		4,173,917	0	4,173,917	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		13,135,788	0	13,135,788	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		7,816,686	0	7,816,686	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		1,754,295	0	1,754,295	55.00
57.00	05700 CT SCAN		2,538,223	0	2,538,223	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		5,999,724	0	5,999,724	58.00
60.00	06000 LABORATORY		5,577,085	0	5,577,085	60.00
64.00	06400 INTRAVENOUS THERAPY		530,491	0	530,491	64.00
65.00	06500 RESPIRATORY THERAPY	0	5,345,164	0	5,345,164	65.00
66.00	06600 PHYSICAL THERAPY	0	7,316,575	0	7,316,575	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,019,600	0	2,019,600	67.00
68.00	06800 SPEECH PATHOLOGY	0	462,870	0	462,870	68.00
69.00	06900 ELECTROCARDIOLOGY		1,910,579	0	1,910,579	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		2,180,520	0	2,180,520	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		13,476,415	0	13,476,415	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		17,892,620	0	17,892,620	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		18,935,261	0	18,935,261	73.00
74.00	07400 RENAL DIALYSIS		833,838	0	833,838	74.00
76.00	03330 ENDOSCOPY		2,703,266	0	2,703,266	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES		0	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICES		0	0	0	76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS		0	0	0	76.04
76.05	03953 MISC ANCILLARY		0	0	0	76.05
76.06	03954 IMAGING CENTER		4,920,572	0	4,920,572	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER		7,064,019	0	7,064,019	76.07
76.08	03956 BARIATRIC CLINIC		13,888	0	13,888	76.08
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
90.24	04973 PALLIATIVE CARE		0	0	0	90.24
90.26	04975 SPINE CENTER		291,290	0	291,290	90.26
90.27	04976 DIABETIC CARE CENTER		0	0	0	90.27
91.00	09100 EMERGENCY		14,037,257	0	14,037,257	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		4,438,268	0	4,438,268	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		245,723,824	0	245,723,824	200.00
201.00	Less Observation Beds		4,438,268		4,438,268	201.00
202.00	Total (see instructions)		241,285,556	0	241,285,556	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/27/2015 6:07 pm	
			Title XIX		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	94,440,486		94,440,486			30.00
31.00	03100	INTENSIVE CARE UNIT	17,335,927		17,335,927			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	71,470,515		71,470,515			35.00
40.00	04000	SUBPROVIDER - I/PF	5,820,250		5,820,250			40.00
41.00	04100	SUBPROVIDER - I/RF	0		0			41.00
43.00	04300	NURSERY	9,735,925		9,735,925			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	85,146,285	35,651,840	120,798,125	0.171278	0.000000	50.00
51.00	05100	RECOVERY ROOM	14,599,179	10,364,265	24,963,444	0.167201	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,258,849	0	26,258,849	0.500242	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,457,301	23,564,090	34,021,391	0.229758	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,431,059	8,606,702	15,037,761	0.116659	0.000000	55.00
57.00	05700	CT SCAN	18,919,757	36,376,232	55,295,989	0.045902	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,417,150	20,828,500	26,245,650	0.228599	0.000000	58.00
60.00	06000	LABORATORY	57,770,485	28,706,102	86,476,587	0.064492	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	1,206,908	158,037	1,364,945	0.388654	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	23,032,308	5,273,757	28,306,065	0.188835	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,084,051	16,070,920	21,154,971	0.345856	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,525,012	970,243	4,495,255	0.449274	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,020,654	518,319	1,538,973	0.300766	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,275,608	979,720	6,255,328	0.305432	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,025,446	6,796,926	7,822,372	0.278754	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,964,229	15,692,123	61,656,352	0.218573	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,414,305	5,700,429	44,114,734	0.405593	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,320,374	14,442,176	74,762,550	0.253272	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,989,829	0	1,989,829	0.419050	0.000000	74.00
76.00	03330	ENDOSCOPY	2,550,837	10,150,109	12,700,946	0.212840	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0.000000	0.000000	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0.000000	0.000000	76.05
76.06	03954	IMAGING CENTER	287,123	46,290,911	46,578,034	0.105641	0.000000	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	22,808	10,841,159	10,863,967	0.650225	0.000000	76.07
76.08	03956	BIATRIC CLINIC	0	67,545	67,545	0.205611	0.000000	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0.000000	0.000000	90.24
90.26	04975	SPINE CENTER	0	732,310	732,310	0.397769	0.000000	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0.000000	0.000000	90.27
91.00	09100	EMERGENCY	26,266,790	86,905,387	113,172,177	0.124035	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,506,037	21,304,140	22,810,177	0.194574	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	641,295,487	406,991,942	1,048,287,429			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	641,295,487	406,991,942	1,048,287,429			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 6:07 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.171278		50.00
51.00	05100 RECOVERY ROOM	0.167201		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.500242		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.229758		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.116659		55.00
57.00	05700 CT SCAN	0.045902		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.228599		58.00
60.00	06000 LABORATORY	0.064492		60.00
64.00	06400 INTRAVENOUS THERAPY	0.388654		64.00
65.00	06500 RESPIRATORY THERAPY	0.188835		65.00
66.00	06600 PHYSICAL THERAPY	0.345856		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.449274		67.00
68.00	06800 SPEECH PATHOLOGY	0.300766		68.00
69.00	06900 ELECTROCARDIOLOGY	0.305432		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278754		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218573		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405593		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.253272		73.00
74.00	07400 RENAL DIALYSIS	0.419050		74.00
76.00	03330 ENDOSCOPY	0.212840		76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES	0.000000		76.02
76.03	03951 OTHER ANCILLARY SERVICES	0.000000		76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS	0.000000		76.04
76.05	03953 MISC ANCILLARY	0.000000		76.05
76.06	03954 IMAGING CENTER	0.105641		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.650225		76.07
76.08	03956 BARIATRIC CLINIC	0.205611		76.08
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
90.24	04973 PALLIATIVE CARE	0.000000		90.24
90.26	04975 SPINE CENTER	0.397769		90.26
90.27	04976 DIABETIC CARE CENTER	0.000000		90.27
91.00	09100 EMERGENCY	0.124035		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.194574		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 150169

Period: From 01/01/2014 To 12/31/2014

Worksheet C Part II Date/Time Prepared: 5/27/2015 6:07 pm

Cost Center Description		Title XIX					Hospital	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	PPS	
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,690,094	3,086,446	17,603,648	0	0	50.00
51.00	05100	RECOVERY ROOM	4,173,917	398,675	3,775,242	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,135,788	1,504,073	11,631,715	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,816,686	1,290,805	6,525,881	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,754,295	343,057	1,411,238	0	0	55.00
57.00	05700	CT SCAN	2,538,223	189,922	2,348,301	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,999,724	939,794	5,059,930	0	0	58.00
60.00	06000	LABORATORY	5,577,085	345,267	5,231,818	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	530,491	31,555	498,936	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,345,164	487,909	4,857,255	0	0	65.00
66.00	06600	PHYSICAL THERAPY	7,316,575	411,682	6,904,893	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,019,600	118,458	1,901,142	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	462,870	27,134	435,736	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,910,579	105,351	1,805,228	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,180,520	213,306	1,967,214	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,476,415	617,343	12,859,072	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,892,620	819,154	17,073,466	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,935,261	1,151,729	17,783,532	0	0	73.00
74.00	07400	RENAL DIALYSIS	833,838	40,852	792,986	0	0	74.00
76.00	03330	ENDOSCOPY	2,703,266	496,645	2,206,621	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0	0	76.05
76.06	03954	IMAGING CENTER	4,920,572	896,493	4,024,079	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	7,064,019	386,269	6,677,750	0	0	76.07
76.08	03956	BARIATRIC CLINIC	13,888	666	13,222	0	0	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0	0	90.24
90.26	04975	SPI NE CENTER	291,290	13,804	277,486	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0	0	90.27
91.00	09100	EMERGENCY	14,037,257	1,163,817	12,873,440	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,438,268	482,258	3,956,010	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	166,058,305	15,562,464	150,495,841	0	0	200.00
201.00		Less Observation Beds	4,438,268	482,258	3,956,010	0	0	201.00
202.00		Total (line 200 minus line 201)	161,620,037	15,080,206	146,539,831	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Prepared: 5/27/2015 6:07 pm
		Title XIX	Hospital	PPS

Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	20,690,094	120,798,125	0.171278	50.00
51.00 05100 RECOVERY ROOM	4,173,917	24,963,444	0.167201	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	13,135,788	26,258,849	0.500242	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	7,816,686	34,021,391	0.229758	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	1,754,295	15,037,761	0.116659	55.00
57.00 05700 CT SCAN	2,538,223	55,295,989	0.045902	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	5,999,724	26,245,650	0.228599	58.00
60.00 06000 LABORATORY	5,577,085	86,476,587	0.064492	60.00
64.00 06400 INTRAVENOUS THERAPY	530,491	1,364,945	0.388654	64.00
65.00 06500 RESPIRATORY THERAPY	5,345,164	28,306,065	0.188835	65.00
66.00 06600 PHYSICAL THERAPY	7,316,575	21,154,971	0.345856	66.00
67.00 06700 OCCUPATIONAL THERAPY	2,019,600	4,495,255	0.449274	67.00
68.00 06800 SPEECH PATHOLOGY	462,870	1,538,973	0.300766	68.00
69.00 06900 ELECTROCARDIOLOGY	1,910,579	6,255,328	0.305432	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2,180,520	7,822,372	0.278754	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,476,415	61,656,352	0.218573	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17,892,620	44,114,734	0.405593	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18,935,261	74,762,550	0.253272	73.00
74.00 07400 RENAL DIALYSIS	833,838	1,989,829	0.419050	74.00
76.00 03330 ENDOSCOPY	2,703,266	12,700,946	0.212840	76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	76.01
76.02 03950 NEUROPSYCHIATRIC SERVICES	0	0	0.000000	76.02
76.03 03951 OTHER ANCILLARY SERVICES	0	0	0.000000	76.03
76.04 03952 ANCILLARY SERVICE COST CENTERS	0	0	0.000000	76.04
76.05 03953 MISCELLANEOUS	0	0	0.000000	76.05
76.06 03954 IMAGING CENTER	4,920,572	46,578,034	0.105641	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	7,064,019	10,863,967	0.650225	76.07
76.08 03956 BARIATRIC CLINIC	13,888	67,545	0.205611	76.08
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0.000000	90.00
90.24 04973 PALLIATIVE CARE	0	0	0.000000	90.24
90.26 04975 SPINE CENTER	291,290	732,310	0.397769	90.26
90.27 04976 DIABETIC CARE CENTER	0	0	0.000000	90.27
91.00 09100 EMERGENCY	14,037,257	113,172,177	0.124035	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,438,268	22,810,177	0.194574	92.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	166,058,305	849,484,326	200.00
201.00	Less Observation Beds	4,438,268	0	201.00
202.00	Total (line 200 minus line 201)	161,620,037	849,484,326	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I Date/Time Prepared: 5/27/2015 6:07 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	5,479,518	0	5,479,518	56,743	96.57	30.00
31.00	INTENSIVE CARE UNIT	728,240		728,240	5,161	141.10	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	1,386,215		1,386,215	11,463	120.93	35.00
40.00	SUBPROVIDER - IPF	309,603	0	309,603	3,120	99.23	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	593,379		593,379	7,861	75.48	43.00
200.00	Total (Lines 30-199)	8,496,955		8,496,955	84,348		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	18,408	1,777,661	30.00
31.00	INTENSIVE CARE UNIT	2,140	301,954	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0	35.00
40.00	SUBPROVIDER - IPF	2,633	261,273	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (Lines 30-199)	23,181	2,340,888	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/27/2015 6:07 pm
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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)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,086,446	120,798,125	0.025550	32,920,568	841,121	50.00
51.00	05100	RECOVERY ROOM	398,675	24,963,444	0.015970	946,121	15,110	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,504,073	26,258,849	0.057279	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,290,805	34,021,391	0.037941	4,265,813	161,849	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	343,057	15,037,761	0.022813	3,258,618	74,339	55.00
57.00	05700	CT SCAN	189,922	55,295,989	0.003435	7,770,085	26,690	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	939,794	26,245,650	0.035808	2,159,260	77,319	58.00
60.00	06000	LABORATORY	345,267	86,476,587	0.003993	21,873,340	87,340	60.00
64.00	06400	INTRAVENOUS THERAPY	31,555	1,364,945	0.023118	493,970	11,420	64.00
65.00	06500	RESPIRATORY THERAPY	487,909	28,306,065	0.017237	7,785,573	134,200	65.00
66.00	06600	PHYSICAL THERAPY	411,682	21,154,971	0.019460	2,422,547	47,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,458	4,495,255	0.026352	1,470,844	38,760	67.00
68.00	06800	SPEECH PATHOLOGY	27,134	1,538,973	0.017631	387,887	6,839	68.00
69.00	06900	ELECTROCARDIOLOGY	105,351	6,255,328	0.016842	2,644,450	44,538	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	213,306	7,822,372	0.027269	443,307	12,089	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	617,343	61,656,352	0.010013	9,658,708	96,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	819,154	44,114,734	0.018569	14,215,954	263,976	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,151,729	74,762,550	0.015405	25,726,533	396,317	73.00
74.00	07400	RENAL DIALYSIS	40,852	1,989,829	0.020530	1,073,535	22,040	74.00
76.00	03330	ENDOSCOPY	496,645	12,700,946	0.039103	1,237,653	48,396	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0.000000	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0.000000	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0.000000	0	0	76.05
76.06	03954	IMAGING CENTER	896,493	46,578,034	0.019247	62,346	1,200	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	386,269	10,863,967	0.035555	1,516	54	76.07
76.08	03956	BARIATRIC CLINIC	666	67,545	0.009860	0	0	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0.000000	0	0	90.24
90.26	04975	SPINE CENTER	13,804	732,310	0.018850	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.27
91.00	09100	EMERGENCY	1,163,817	113,172,177	0.010284	11,237,413	115,566	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	482,258	22,810,177	0.021142	582,622	12,318	92.00
200.00		Total (lines 50-199)	15,562,464	849,484,326		152,638,663	2,535,337	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/27/2015 6:07 pm	
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	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	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	56,743	0.00	18,408	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,161	0.00	2,140	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,463	0.00	0	0	0	35.00
40.00	04000	SUBPROVIDER - I PF	3,120	0.00	2,633	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0.00	0	0	0	41.00
43.00	04300	NURSERY	7,861	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	84,348		23,181	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 6:07 pm
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	11,006	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	650,763	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0	76.05
76.06	03954	IMAGING CENTER	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	76.07
76.08	03956	BARIATRIC CLINIC	0	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0	90.24
90.26	04975	SPI NE CENTER	0	0	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0	90.27
91.00	09100	EMERGENCY	0	0	157,280	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	819,049	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 6:07 pm
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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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	120,798,125	0.000000	0.000000	32,920,568	50.00
51.00	05100	RECOVERY ROOM	0	24,963,444	0.000000	0.000000	946,121	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	26,258,849	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,006	34,021,391	0.000324	0.000324	4,265,813	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,037,761	0.000000	0.000000	3,258,618	55.00
57.00	05700	CT SCAN	0	55,295,989	0.000000	0.000000	7,770,085	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,245,650	0.000000	0.000000	2,159,260	58.00
60.00	06000	LABORATORY	0	86,476,587	0.000000	0.000000	21,873,340	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,364,945	0.000000	0.000000	493,970	64.00
65.00	06500	RESPIRATORY THERAPY	0	28,306,065	0.000000	0.000000	7,785,573	65.00
66.00	06600	PHYSICAL THERAPY	0	21,154,971	0.000000	0.000000	2,422,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,495,255	0.000000	0.000000	1,470,844	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,538,973	0.000000	0.000000	387,887	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,255,328	0.000000	0.000000	2,644,450	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,822,372	0.000000	0.000000	443,307	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	61,656,352	0.000000	0.000000	9,658,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	44,114,734	0.000000	0.000000	14,215,954	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	650,763	74,762,550	0.008704	0.008704	25,726,533	73.00
74.00	07400	RENAL DIALYSIS	0	1,989,829	0.000000	0.000000	1,073,535	74.00
76.00	03330	ENDOSCOPY	0	12,700,946	0.000000	0.000000	1,237,653	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0.000000	0.000000	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0.000000	0.000000	0	76.05
76.06	03954	IMAGING CENTER	0	46,578,034	0.000000	0.000000	62,346	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	10,863,967	0.000000	0.000000	1,516	76.07
76.08	03956	BARIATRIC CLINIC	0	67,545	0.000000	0.000000	0	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0.000000	0.000000	0	90.24
90.26	04975	SPINE CENTER	0	732,310	0.000000	0.000000	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0.000000	0.000000	0	90.27
91.00	09100	EMERGENCY	157,280	113,172,177	0.001390	0.001390	11,237,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,810,177	0.000000	0.000000	582,622	92.00
200.00		Total (lines 50-199)	819,049	849,484,326			152,638,663	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 6:07 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	7,974,417	0	50.00
51.00	05100 RECOVERY ROOM	0	790,811	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,382	4,569,845	1,481	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	4,108,541	0	55.00
57.00	05700 CT SCAN	0	7,720,002	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,421,072	0	58.00
60.00	06000 LABORATORY	0	5,988,637	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	46,130	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,646,274	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	247,300	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,132,840	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	384,401	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	765,300	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	223,924	4,483,982	39,029	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03330 ENDOSCOPY	0	3,775,446	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES	0	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICES	0	0	0	76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS	0	0	0	76.04
76.05	03953 MISC ANCILLARY	0	0	0	76.05
76.06	03954 IMAGING CENTER	0	9,893,643	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	661,359	0	76.07
76.08	03956 BARIATRIC CLINIC	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.24	04973 PALLIATIVE CARE	0	0	0	90.24
90.26	04975 SPINE CENTER	0	0	0	90.26
90.27	04976 DIABETIC CARE CENTER	0	0	0	90.27
91.00	09100 EMERGENCY	15,620	12,531,552	17,419	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,968,252	0	92.00
200.00	Total (Lines 50-199)	240,926	72,109,804	57,929	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 6:07 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.171278	7,974,417	0	0	1,365,842	50.00
51.00	05100 RECOVERY ROOM	0.167201	790,811	0	0	132,224	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.500242	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.229758	4,569,845	0	0	1,049,958	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.116659	4,108,541	0	0	479,298	55.00
57.00	05700 CT SCAN	0.045902	7,720,002	0	0	354,364	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.228599	3,421,072	0	0	782,054	58.00
60.00	06000 LABORATORY	0.064492	5,988,637	341	0	386,219	60.00
64.00	06400 INTRAVENOUS THERAPY	0.388654	46,130	0	0	17,929	64.00
65.00	06500 RESPIRATORY THERAPY	0.188835	1,646,274	0	0	310,874	65.00
66.00	06600 PHYSICAL THERAPY	0.345856	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.449274	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.300766	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.305432	247,300	0	0	75,533	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278754	1,132,840	0	0	315,784	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218573	384,401	0	0	84,020	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405593	765,300	0	0	310,400	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.253272	4,483,982	0	111,506	1,135,667	73.00
74.00	07400 RENAL DIALYSIS	0.419050	0	0	0	0	74.00
76.00	03330 ENDOSCOPY	0.212840	3,775,446	0	0	803,566	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES	0.000000	0	0	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICES	0.000000	0	0	0	0	76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.04
76.05	03953 MISC ANCILLARY	0.000000	0	0	0	0	76.05
76.06	03954 IMAGING CENTER	0.105641	9,893,643	0	0	1,045,174	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.650225	661,359	0	0	430,032	76.07
76.08	03956 BARIATRIC CLINIC	0.205611	0	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.24	04973 PALLIATIVE CARE	0.000000	0	0	0	0	90.24
90.26	04975 SPINE CENTER	0.397769	0	0	0	0	90.26
90.27	04976 DIABETIC CARE CENTER	0.000000	0	0	0	0	90.27
91.00	09100 EMERGENCY	0.124035	12,531,552	0	0	1,554,351	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.194574	1,968,252	0	0	382,971	92.00
200.00	Subtotal (see instructions)		72,109,804	341	111,506	11,016,260	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		72,109,804	341	111,506	11,016,260	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 6:07 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 06000 LABORATORY	22	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	28,241		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	0	0		76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.01
76.02 03950 NEUROPSYCHIATRIC SERVICES	0	0		76.02
76.03 03951 OTHER ANCILLARY SERVICES	0	0		76.03
76.04 03952 ANCILLARY SERVICE COST CENTERS	0	0		76.04
76.05 03953 MISC ANCILLARY	0	0		76.05
76.06 03954 IMAGING CENTER	0	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		76.07
76.08 03956 BARIATRIC CLINIC	0	0		76.08
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.24 04973 PALLIATIVE CARE	0	0		90.24
90.26 04975 SPINE CENTER	0	0		90.26
90.27 04976 DIABETIC CARE CENTER	0	0		90.27
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	22	28,241		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	22	28,241		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150169 Component CCN: 15S169		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/27/2015 6:07 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	3,086,446	120,798,125	0.025550	65,088	1,663	50.00
51.00	05100	RECOVERY ROOM	398,675	24,963,444	0.015970	50,730	810	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,504,073	26,258,849	0.057279	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,290,805	34,021,391	0.037941	41,854	1,588	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	343,057	15,037,761	0.022813	0	0	55.00
57.00	05700	CT SCAN	189,922	55,295,989	0.003435	76,219	262	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	939,794	26,245,650	0.035808	10,389	372	58.00
60.00	06000	LABORATORY	345,267	86,476,587	0.003993	637,293	2,545	60.00
64.00	06400	INTRAVENOUS THERAPY	31,555	1,364,945	0.023118	20,216	467	64.00
65.00	06500	RESPIRATORY THERAPY	487,909	28,306,065	0.017237	39,091	674	65.00
66.00	06600	PHYSICAL THERAPY	411,682	21,154,971	0.019460	92,353	1,797	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,458	4,495,255	0.026352	55,968	1,475	67.00
68.00	06800	SPEECH PATHOLOGY	27,134	1,538,973	0.017631	10,512	185	68.00
69.00	06900	ELECTROCARDIOLOGY	105,351	6,255,328	0.016842	13,440	226	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	213,306	7,822,372	0.027269	10,304	281	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	617,343	61,656,352	0.010013	29,559	296	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	819,154	44,114,734	0.018569	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,151,729	74,762,550	0.015405	905,247	13,945	73.00
74.00	07400	RENAL DIALYSIS	40,852	1,989,829	0.020530	0	0	74.00
76.00	03330	ENDOSCOPY	496,645	12,700,946	0.039103	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0.000000	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0.000000	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0.000000	0	0	76.05
76.06	03954	IMAGING CENTER	896,493	46,578,034	0.019247	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	386,269	10,863,967	0.035555	0	0	76.07
76.08	03956	BARITRIC CLINIC	666	67,545	0.009860	0	0	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0.000000	0	0	90.24
90.26	04975	SPINE CENTER	13,804	732,310	0.018850	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.27
91.00	09100	EMERGENCY	1,163,817	113,172,177	0.010284	211,520	2,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,810,177	0.000000	0	0	92.00
200.00		Total (lines 50-199)	15,080,206	849,484,326		2,269,783	28,761	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150169 Component CCN: 15S169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 6:07 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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	11,006	11,006	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	650,763	650,763	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0	76.05
76.06	03954	IMAGING CENTER	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	76.07
76.08	03956	BARIATRIC CLINIC	0	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0	90.24
90.26	04975	SPIRE CENTER	0	0	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0	90.27
91.00	09100	EMERGENCY	0	0	157,280	157,280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	819,049	819,049	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150169 Component CCN: 15S169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 6:07 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	120,798,125	0.000000	0.000000	65,088	50.00
51.00 05100 RECOVERY ROOM	0	24,963,444	0.000000	0.000000	50,730	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	26,258,849	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	11,006	34,021,391	0.000324	0.000324	41,854	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	15,037,761	0.000000	0.000000	0	55.00
57.00 05700 CT SCAN	0	55,295,989	0.000000	0.000000	76,219	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	26,245,650	0.000000	0.000000	10,389	58.00
60.00 06000 LABORATORY	0	86,476,587	0.000000	0.000000	637,293	60.00
64.00 06400 INTRAVENOUS THERAPY	0	1,364,945	0.000000	0.000000	20,216	64.00
65.00 06500 RESPIRATORY THERAPY	0	28,306,065	0.000000	0.000000	39,091	65.00
66.00 06600 PHYSICAL THERAPY	0	21,154,971	0.000000	0.000000	92,353	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	4,495,255	0.000000	0.000000	55,968	67.00
68.00 06800 SPEECH PATHOLOGY	0	1,538,973	0.000000	0.000000	10,512	68.00
69.00 06900 ELECTROCARDIOLOGY	0	6,255,328	0.000000	0.000000	13,440	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	7,822,372	0.000000	0.000000	10,304	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	61,656,352	0.000000	0.000000	29,559	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	44,114,734	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	650,763	74,762,550	0.008704	0.008704	905,247	73.00
74.00 07400 RENAL DIALYSIS	0	1,989,829	0.000000	0.000000	0	74.00
76.00 03330 ENDOSCOPY	0	12,700,946	0.000000	0.000000	0	76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.01
76.02 03950 NEUROPSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	76.02
76.03 03951 OTHER ANCILLARY SERVICES	0	0	0.000000	0.000000	0	76.03
76.04 03952 ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.04
76.05 03953 MISC ANCILLARY	0	0	0.000000	0.000000	0	76.05
76.06 03954 IMAGING CENTER	0	46,578,034	0.000000	0.000000	0	76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	10,863,967	0.000000	0.000000	0	76.07
76.08 03956 BARIATRIC CLINIC	0	67,545	0.000000	0.000000	0	76.08
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.24 04973 PALLIATIVE CARE	0	0	0.000000	0.000000	0	90.24
90.26 04975 SPINE CENTER	0	732,310	0.000000	0.000000	0	90.26
90.27 04976 DIABETIC CARE CENTER	0	0	0.000000	0.000000	0	90.27
91.00 09100 EMERGENCY	157,280	113,172,177	0.001390	0.001390	211,520	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	22,810,177	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	819,049	849,484,326			2,269,783	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150169 Component CCN: 15S169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 6:07 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
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	14	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,879	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03330 ENDOSCOPY	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES	0	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICES	0	0	0	76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS	0	0	0	76.04
76.05	03953 MISC ANCILLARY	0	0	0	76.05
76.06	03954 IMAGING CENTER	0	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	0	76.07
76.08	03956 BARIATRIC CLINIC	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.24	04973 PALLIATIVE CARE	0	0	0	90.24
90.26	04975 SPINE CENTER	0	0	0	90.26
90.27	04976 DIABETIC CARE CENTER	0	0	0	90.27
91.00	09100 EMERGENCY	294	775	1	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	8,187	775	1	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 6:07 pm	
		Component CCN: 15S169	Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.171278	0	0	0
51.00	05100 RECOVERY ROOM	0.167201	0	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.500242	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.229758	0	0	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0.116659	0	0	0
57.00	05700 CT SCAN	0.045902	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.228599	0	0	0
60.00	06000 LABORATORY	0.064492	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0.388654	0	0	0
65.00	06500 RESPIRATORY THERAPY	0.188835	0	0	0
66.00	06600 PHYSICAL THERAPY	0.345856	0	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.449274	0	0	0
68.00	06800 SPEECH PATHOLOGY	0.300766	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.305432	0	0	0
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278754	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218573	0	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405593	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.253272	0	0	2,321
74.00	07400 RENAL DIALYSIS	0.419050	0	0	0
76.00	03330 ENDOSCOPY	0.212840	0	0	0
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0
76.02	03950 NEUROPSYCHIATRIC SERVICES	0.000000	0	0	0
76.03	03951 OTHER ANCILLARY SERVICES	0.000000	0	0	0
76.04	03952 ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0
76.05	03953 MISC ANCILLARY	0.000000	0	0	0
76.06	03954 IMAGING CENTER	0.105641	0	0	0
76.07	03955 BREAST DIAGNOSTIC CENTER	0.650225	0	0	0
76.08	03956 BARIATRIC CLINIC	0.205611	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	0
90.24	04973 PALLIATIVE CARE	0.000000	0	0	0
90.26	04975 SPINE CENTER	0.397769	0	0	0
90.27	04976 DIABETIC CARE CENTER	0.000000	0	0	0
91.00	09100 EMERGENCY	0.124035	775	0	96
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.194574	0	0	0
200.00	Subtotal (see instructions)		775	0	2,321
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0
202.00	Net Charges (line 200 +/- line 201)		775	0	2,321

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 6:07 pm
	Component CCN: 15S169	Title XVII I	Subprovider - IPF

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	588		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03330 ENDOSCOPY	0	0		76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.01
76.02 03950 NEUROPSYCHIATRIC SERVICES	0	0		76.02
76.03 03951 OTHER ANCILLARY SERVICES	0	0		76.03
76.04 03952 ANCILLARY SERVICE COST CENTERS	0	0		76.04
76.05 03953 MISC ANCILLARY	0	0		76.05
76.06 03954 IMAGING CENTER	0	0		76.06
76.07 03955 BREAST DIAGNOSTIC CENTER	0	0		76.07
76.08 03956 BARIATRIC CLINIC	0	0		76.08
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.24 04973 PALLIATIVE CARE	0	0		90.24
90.26 04975 SPINE CENTER	0	0		90.26
90.27 04976 DIABETIC CARE CENTER	0	0		90.27
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	0	588		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	588		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I Date/Time Prepared: 5/27/2015 6:07 pm
		Title XIX	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,479,518	0	5,479,518	56,743	96.57	30.00
31.00	INTENSIVE CARE UNIT	728,240		728,240	5,161	141.10	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	1,386,215		1,386,215	11,463	120.93	35.00
40.00	SUBPROVIDER - IPF	309,603	0	309,603	3,120	99.23	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	593,379		593,379	7,861	75.48	43.00
200.00	Total (Lines 30-199)	8,496,955		8,496,955	84,348		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	2,566	247,799				
31.00	INTENSIVE CARE UNIT	0	0				
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	0	0				
43.00	NURSERY	1,485	112,088				
200.00	Total (Lines 30-199)	4,051	359,887				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/27/2015 6:07 pm
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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)	Title XIX		Capital Costs (column 3 x column 4)	
					Hospital	Inpatient Program Charges		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,086,446	120,798,125	0.025550	2,936,787	75,035	50.00
51.00	05100	RECOVERY ROOM	398,675	24,963,444	0.015970	526,258	8,404	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,504,073	26,258,849	0.057279	545,055	31,220	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,290,805	34,021,391	0.037941	534,674	20,286	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	343,057	15,037,761	0.022813	345,371	7,879	55.00
57.00	05700	CT SCAN	189,922	55,295,989	0.003435	891,369	3,062	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	939,794	26,245,650	0.035808	190,516	6,822	58.00
60.00	06000	LABORATORY	345,267	86,476,587	0.003993	3,331,475	13,303	60.00
64.00	06400	INTRAVENOUS THERAPY	31,555	1,364,945	0.023118	76,231	1,762	64.00
65.00	06500	RESPIRATORY THERAPY	487,909	28,306,065	0.017237	1,557,380	26,845	65.00
66.00	06600	PHYSICAL THERAPY	411,682	21,154,971	0.019460	157,901	3,073	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,458	4,495,255	0.026352	163,051	4,297	67.00
68.00	06800	SPEECH PATHOLOGY	27,134	1,538,973	0.017631	62,065	1,094	68.00
69.00	06900	ELECTROCARDIOLOGY	105,351	6,255,328	0.016842	320,550	5,399	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	213,306	7,822,372	0.027269	68,836	1,877	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	617,343	61,656,352	0.010013	1,843,313	18,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	819,154	44,114,734	0.018569	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,151,729	74,762,550	0.015405	4,058,934	62,528	73.00
74.00	07400	RENAL DIALYSIS	40,852	1,989,829	0.020530	133,874	2,748	74.00
76.00	03330	ENDOSCOPY	496,645	12,700,946	0.039103	126,438	4,944	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0.000000	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0.000000	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0.000000	0	0	76.05
76.06	03954	IMAGING CENTER	896,493	46,578,034	0.019247	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	386,269	10,863,967	0.035555	949	34	76.07
76.08	03956	BARIATRIC CLINIC	666	67,545	0.009860	0	0	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0.000000	0	0	90.24
90.26	04975	SPINE CENTER	13,804	732,310	0.018850	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0.000000	0	0	90.27
91.00	09100	EMERGENCY	1,163,817	113,172,177	0.010284	1,211,075	12,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	482,258	22,810,177	0.021142	180,319	3,812	92.00
200.00		Total (lines 50-199)	15,562,464	849,484,326		19,262,421	315,336	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/27/2015 6:07 pm	
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	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	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	56,743	0.00	2,566	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,161	0.00	0	0		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	11,463	0.00	0	0		35.00
40.00	04000	SUBPROVIDER - I PF	3,120	0.00	0	0		40.00
41.00	04100	SUBPROVIDER - I RF	0	0.00	0	0		41.00
43.00	04300	NURSERY	7,861	0.00	1,485	0		43.00
200.00		Total (lines 30-199)	84,348		4,051	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 6:07 pm
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Cost Center Description		Title XIX				Hospital	PPS
		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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	11,006	0	11,006 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	650,763	0	650,763 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0	0	76.05
76.06	03954	IMAGING CENTER	0	0	0	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	0	0	0	76.07
76.08	03956	BARIATRIC CLINIC	0	0	0	0	76.08
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0	0	90.24
90.26	04975	SPI NE CENTER	0	0	0	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0	0	90.27
91.00	09100	EMERGENCY	0	0	157,280	0	157,280 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	819,049	0	819,049 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 6:07 pm
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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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	120,798,125	0.000000	0.000000	2,936,787	50.00
51.00	05100	RECOVERY ROOM	0	24,963,444	0.000000	0.000000	526,258	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	26,258,849	0.000000	0.000000	545,055	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,006	34,021,391	0.000324	0.000324	534,674	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,037,761	0.000000	0.000000	345,371	55.00
57.00	05700	CT SCAN	0	55,295,989	0.000000	0.000000	891,369	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	26,245,650	0.000000	0.000000	190,516	58.00
60.00	06000	LABORATORY	0	86,476,587	0.000000	0.000000	3,331,475	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,364,945	0.000000	0.000000	76,231	64.00
65.00	06500	RESPIRATORY THERAPY	0	28,306,065	0.000000	0.000000	1,557,380	65.00
66.00	06600	PHYSICAL THERAPY	0	21,154,971	0.000000	0.000000	157,901	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,495,255	0.000000	0.000000	163,051	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,538,973	0.000000	0.000000	62,065	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,255,328	0.000000	0.000000	320,550	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,822,372	0.000000	0.000000	68,836	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	61,656,352	0.000000	0.000000	1,843,313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	44,114,734	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	650,763	74,762,550	0.008704	0.008704	4,058,934	73.00
74.00	07400	RENAL DIALYSIS	0	1,989,829	0.000000	0.000000	133,874	74.00
76.00	03330	ENDOSCOPY	0	12,700,946	0.000000	0.000000	126,438	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0	0	0.000000	0.000000	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.04
76.05	03953	MISC ANCILLARY	0	0	0.000000	0.000000	0	76.05
76.06	03954	IMAGING CENTER	0	46,578,034	0.000000	0.000000	0	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0	10,863,967	0.000000	0.000000	949	76.07
76.08	03956	BARIATRIC CLINIC	0	67,545	0.000000	0.000000	0	76.08
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.24	04973	PALLIATIVE CARE	0	0	0.000000	0.000000	0	90.24
90.26	04975	SPINE CENTER	0	732,310	0.000000	0.000000	0	90.26
90.27	04976	DIABETIC CARE CENTER	0	0	0.000000	0.000000	0	90.27
91.00	09100	EMERGENCY	157,280	113,172,177	0.001390	0.001390	1,211,075	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,810,177	0.000000	0.000000	180,319	92.00
200.00		Total (lines 50-199)	819,049	849,484,326			19,262,421	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 6:07 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	173	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	35,329	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03330 ENDOSCOPY	0	0	0		76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES	0	0	0		76.02
76.03	03951 OTHER ANCILLARY SERVICES	0	0	0		76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS	0	0	0		76.04
76.05	03953 MISC ANCILLARY	0	0	0		76.05
76.06	03954 IMAGING CENTER	0	0	0		76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0	0	0		76.07
76.08	03956 BARIATRIC CLINIC	0	0	0		76.08
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.24	04973 PALLIATIVE CARE	0	0	0		90.24
90.26	04975 SPINE CENTER	0	0	0		90.26
90.27	04976 DIABETIC CARE CENTER	0	0	0		90.27
91.00	09100 EMERGENCY	1,683	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	37,185	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 6:07 pm
		Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.171278	0	1,236,335	0	0
51.00 05100 RECOVERY ROOM	0.167201	0	81,967	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.500242	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.229758	0	1,159,213	0	0
55.00 05500 RADIOLOGY-THERAPEUTIC	0.116659	0	470,033	0	0
57.00 05700 CT SCAN	0.045902	0	1,621,146	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.228599	0	585,414	0	0
60.00 06000 LABORATORY	0.064492	0	1,648,716	0	0
64.00 06400 INTRAVENOUS THERAPY	0.388654	0	13,459	0	0
65.00 06500 RESPIRATORY THERAPY	0.188835	0	144,550	0	0
66.00 06600 PHYSICAL THERAPY	0.345856	0	180,905	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.449274	0	31,300	0	0
68.00 06800 SPEECH PATHOLOGY	0.300766	0	42,779	0	0
69.00 06900 ELECTROCARDIOLOGY	0.305432	0	14,923	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.278754	0	129,797	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218573	0	364,028	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.405593	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.253272	0	733,988	0	0
74.00 07400 RENAL DIALYSIS	0.419050	0	0	0	0
76.00 03330 ENDOSCOPY	0.212840	0	203,363	0	0
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0
76.02 03950 NEUROPSYCHIATRIC SERVICES	0.000000	0	0	0	0
76.03 03951 OTHER ANCILLARY SERVICES	0.000000	0	0	0	0
76.04 03952 ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0
76.05 03953 MISC ANCILLARY	0.000000	0	0	0	0
76.06 03954 IMAGING CENTER	0.105641	0	717,888	0	0
76.07 03955 BREAST DIAGNOSTIC CENTER	0.650225	0	104,721	0	0
76.08 03956 BARIATRIC CLINIC	0.205611	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.000000	0	0	0	0
90.24 04973 PALLIATIVE CARE	0.000000	0	0	0	0
90.26 04975 SPINE CENTER	0.397769	0	0	0	0
90.27 04976 DIABETIC CARE CENTER	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.124035	0	6,376,820	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.194574	0	1,478,928	0	0
200.00	Subtotal (see instructions)	0	17,340,273	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0
202.00	Net Charges (line 200 +/- line 201)	0	17,340,273	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 6:07 pm
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	211,757	0	50.00
51.00	05100 RECOVERY ROOM	13,705	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	266,338	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	54,834	0	55.00
57.00	05700 CT SCAN	74,414	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	133,825	0	58.00
60.00	06000 LABORATORY	106,329	0	60.00
64.00	06400 INTRAVENOUS THERAPY	5,231	0	64.00
65.00	06500 RESPIRATORY THERAPY	27,296	0	65.00
66.00	06600 PHYSICAL THERAPY	62,567	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	14,062	0	67.00
68.00	06800 SPEECH PATHOLOGY	12,866	0	68.00
69.00	06900 ELECTROCARDIOLOGY	4,558	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	36,181	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	79,567	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	185,899	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03330 ENDOSCOPY	43,284	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICES	0	0	76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS	0	0	76.04
76.05	03953 MISC ANCILLARY	0	0	76.05
76.06	03954 IMAGING CENTER	75,838	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	68,092	0	76.07
76.08	03956 BARIATRIC CLINIC	0	0	76.08
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.24	04973 PALLIATIVE CARE	0	0	90.24
90.26	04975 SPINE CENTER	0	0	90.26
90.27	04976 DIABETIC CARE CENTER	0	0	90.27
91.00	09100 EMERGENCY	790,949	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	287,761	0	92.00
200.00	Subtotal (see instructions)	2,555,353	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,555,353	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/27/2015 6:07 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		56,743	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		56,743	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)		51,749	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)		18,408	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)		50,428,620	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)		50,428,620	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)		50,428,620	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)		888.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		16,359,558	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)		16,359,558	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 6:07 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	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	8,150,065	5,161	1,579.16	2,140	3,379,402	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	NEONATAL INTENSIVE CARE UNIT	12,990,494	11,463	1,133.25	0	0	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					30,247,597	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49,986,557	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)					2,079,615	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,776,263	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,855,878	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					45,130,679	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)					4,994	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					888.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,438,268	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/27/2015 6:07 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	5,479,518	50,428,620	0.108659	4,438,268	482,258	90.00
91.00	Nursing School cost	0	50,428,620	0.000000	4,438,268	0	91.00
92.00	Allied health cost	0	50,428,620	0.000000	4,438,268	0	92.00
93.00	All other Medical Education	0	50,428,620	0.000000	4,438,268	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150169 Component CCN: 15S169	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 6:07 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)		3,120	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,120	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)		3,120	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)		2,633	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)		2,805,150	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)		2,805,150	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)		2,805,150	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)		899.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,367,304	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)		2,367,304	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 15S169				Date/Time Prepared: 5/27/2015 6:07 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	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					420,655		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,787,959		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)					261,273		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					36,948		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					298,221		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,489,738		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: 150169 Component CCN: 15S169		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/27/2015 6:07 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	309,603	2,805,150	0.110369	0	0	90.00
91.00	Nursing School cost	0	2,805,150	0.000000	0	0	91.00
92.00	Allied health cost	0	2,805,150	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,805,150	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/27/2015 6:07 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		56,743	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		56,743	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)		51,749	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)		2,566	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)		7,861	15.00
16.00	Nursery days (title V or XIX only)		1,485	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)		50,428,620	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)		50,428,620	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)		50,428,620	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)		888.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,280,456	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)		2,280,456	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 6:07 pm		
Cost Center Description			Title XIX	Hospital	PPS		
	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)	5,291,190	7,861	673.09	1,485	999,539	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,150,065	5,161	1,579.16	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	NEONATAL INTENSIVE CARE UNIT	12,990,494	11,463	1,133.25	0	0	47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				3,613,298		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				6,893,293		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)				359,887		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				352,521		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				712,408		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				6,180,885		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)				4,994		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				888.72		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				4,438,268		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150169		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/27/2015 6:07 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	5,479,518	50,428,620	0.108659	4,438,268	482,258	90.00
91.00	Nursing School cost	0	50,428,620	0.000000	4,438,268	0	91.00
92.00	Allied health cost	0	50,428,620	0.000000	4,438,268	0	92.00
93.00	All other Medical Education	0	50,428,620	0.000000	4,438,268	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/27/2015 6:07 pm	
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		29,532,548	30.00
31.00	03100	INTENSIVE CARE UNIT		7,557,405	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
41.00	04100	SUBPROVIDER - I/RF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.171278	32,920,568	50.00
51.00	05100	RECOVERY ROOM	0.167201	946,121	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.500242	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.229758	4,265,813	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.116659	3,258,618	55.00
57.00	05700	CT SCAN	0.045902	7,770,085	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.228599	2,159,260	58.00
60.00	06000	LABORATORY	0.064492	21,873,340	60.00
64.00	06400	INTRAVENOUS THERAPY	0.388654	493,970	64.00
65.00	06500	RESPIRATORY THERAPY	0.188835	7,785,573	65.00
66.00	06600	PHYSICAL THERAPY	0.345856	2,422,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.449274	1,470,844	67.00
68.00	06800	SPEECH PATHOLOGY	0.300766	387,887	68.00
69.00	06900	ELECTROCARDIOLOGY	0.305432	2,644,450	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.278754	443,307	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218573	9,658,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405593	14,215,954	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253272	25,726,533	73.00
74.00	07400	RENAL DIALYSIS	0.419050	1,073,535	74.00
76.00	03330	ENDOSCOPY	0.212840	1,237,653	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	76.01
76.02	03950	NEUROPSYCHIATRIC SERVICES	0.000000	0	76.02
76.03	03951	OTHER ANCILLARY SERVICES	0.000000	0	76.03
76.04	03952	ANCILLARY SERVICE COST CENTERS	0.000000	0	76.04
76.05	03953	MISC ANCILLARY	0.000000	0	76.05
76.06	03954	IMAGING CENTER	0.105641	62,346	76.06
76.07	03955	BREAST DIAGNOSTIC CENTER	0.650225	1,516	76.07
76.08	03956	BARIATRIC CLINIC	0.205611	0	76.08
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.24	04973	PALLIATIVE CARE	0.000000	0	90.24
90.26	04975	SPINE CENTER	0.397769	0	90.26
90.27	04976	DIABETIC CARE CENTER	0.000000	0	90.27
91.00	09100	EMERGENCY	0.124035	11,237,413	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.194574	582,622	92.00
200.00		Total (sum of lines 50-94 and 96-98)		152,638,663	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)		152,638,663	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3	
		Component CCN: 15S169		Date/Time Prepared: 5/27/2015 6:07 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
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		4,932,096		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.171278	65,088	11,148	50.00
51.00	05100 RECOVERY ROOM	0.167201	50,730	8,482	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.500242	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.229758	41,854	9,616	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.116659	0	0	55.00
57.00	05700 CT SCAN	0.045902	76,219	3,499	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.228599	10,389	2,375	58.00
60.00	06000 LABORATORY	0.064492	637,293	41,100	60.00
64.00	06400 INTRAVENOUS THERAPY	0.388654	20,216	7,857	64.00
65.00	06500 RESPIRATORY THERAPY	0.188835	39,091	7,382	65.00
66.00	06600 PHYSICAL THERAPY	0.345856	92,353	31,941	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.449274	55,968	25,145	67.00
68.00	06800 SPEECH PATHOLOGY	0.300766	10,512	3,162	68.00
69.00	06900 ELECTROCARDIOLOGY	0.305432	13,440	4,105	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.278754	10,304	2,872	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218573	29,559	6,461	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.405593	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.253272	905,247	229,274	73.00
74.00	07400 RENAL DIALYSIS	0.419050	0	0	74.00
76.00	03330 ENDOSCOPY	0.212840	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.01
76.02	03950 NEUROPSYCHIATRIC SERVICES	0.000000	0	0	76.02
76.03	03951 OTHER ANCILLARY SERVICES	0.000000	0	0	76.03
76.04	03952 ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.04
76.05	03953 MISC ANCILLARY	0.000000	0	0	76.05
76.06	03954 IMAGING CENTER	0.105641	0	0	76.06
76.07	03955 BREAST DIAGNOSTIC CENTER	0.650225	0	0	76.07
76.08	03956 BARIATRIC CLINIC	0.205611	0	0	76.08
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.24	04973 PALLIATIVE CARE	0.000000	0	0	90.24
90.26	04975 SPINE CENTER	0.397769	0	0	90.26
90.27	04976 DIABETIC CARE CENTER	0.000000	0	0	90.27
91.00	09100 EMERGENCY	0.124035	211,520	26,236	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.194574	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,269,783	420,655	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		2,269,783		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/27/2015 6:07 pm
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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			30.00
31.00	03100	INTENSIVE CARE UNIT		4,386,543	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		1,409,610	35.00
40.00	04000	SUBPROVIDER - I PF		7,932,849	40.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
43.00	04300	NURSERY		0	43.00
				467,295	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.171278	2,936,787	503,007
51.00	05100	RECOVERY ROOM	0.167201	526,258	87,991
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.500242	545,055	272,659
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.229758	534,674	122,846
55.00	05500	RADIOLOGY-THERAPEUTIC	0.116659	345,371	40,291
57.00	05700	CT SCAN	0.045902	891,369	40,916
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.228599	190,516	43,552
60.00	06000	LABORATORY	0.064492	3,331,475	214,853
64.00	06400	INTRAVENOUS THERAPY	0.388654	76,231	29,627
65.00	06500	RESPIRATORY THERAPY	0.188835	1,557,380	294,088
66.00	06600	PHYSICAL THERAPY	0.345856	157,901	54,611
67.00	06700	OCCUPATIONAL THERAPY	0.449274	163,051	73,255
68.00	06800	SPEECH PATHOLOGY	0.300766	62,065	18,667
69.00	06900	ELECTROCARDIOLOGY	0.305432	320,550	97,906
70.00	07000	ELECTROENCEPHALOGRAPHY	0.278754	68,836	19,188
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.218573	1,843,313	402,898
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.405593	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.253272	4,058,934	1,028,014
74.00	07400	RENAL DIALYSIS	0.419050	133,874	56,100
76.00	03330	ENDOSCOPY	0.212840	126,438	26,911
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0
76.02	03950	NEUROPSYCHIATRIC SERVICES	0.000000	0	0
76.03	03951	OTHER ANCILLARY SERVICES	0.000000	0	0
76.04	03952	ANCILLARY SERVICE COST CENTERS	0.000000	0	0
76.05	03953	MISC ANCILLARY	0.000000	0	0
76.06	03954	IMAGING CENTER	0.105641	0	0
76.07	03955	BREAST DIAGNOSTIC CENTER	0.650225	949	617
76.08	03956	BARIATRIC CLINIC	0.205611	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0
90.24	04973	PALLIATIVE CARE	0.000000	0	0
90.26	04975	SPI NE CENTER	0.397769	0	0
90.27	04976	DIABETIC CARE CENTER	0.000000	0	0
91.00	09100	EMERGENCY	0.124035	1,211,075	150,216
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.194574	180,319	35,085
200.00		Total (sum of lines 50-94 and 96-98)		19,262,421	3,613,298
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	
202.00		Net Charges (line 200 minus line 201)		19,262,421	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/27/2015 6:07 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)		29,153,747	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,809,589	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)		1,886,105	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		12,069,854	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		269.07	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).		0.87	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)		0.87	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		1.89	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)		0.87	12.00
13.00	Total allowable FTE count for the prior year.		1.20	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.		1.19	14.00
15.00	Sum of lines 12 through 14 divided by 3.		1.09	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		1.09	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.004051	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.004890	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.004051	21.00
22.00	IME payment adjustment (see instructions)		112,936	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)		1.02	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)		112,936	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)		3.36	30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.98	31.00
32.00	Sum of lines 30 and 31		28.34	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.60	33.00
34.00	Disproportionate share adjustment (see instructions)		1,227,345	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/27/2015 6:07 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000434617	0.000486452	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		3,931,711	3,720,209	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,940,704	937,697	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,878,401		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 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 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 and 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)		46,068,123		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)		46,068,123		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,570,707		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).		37,219		52.00
53.00	Nursing and Allied Health Managed Care payment		49,770		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 instructions)		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)		240,926		58.00
59.00	Total (sum of amounts on lines 49 through 58)		49,966,745		59.00
60.00	Primary payer payments		26,896		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		49,939,849		61.00
62.00	Deductibles billed to program beneficiaries		3,541,924		62.00
63.00	Coinurance billed to program beneficiaries		169,824		63.00
64.00	Allowable bad debts (see instructions)		-117,963		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		-76,676		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		-168,681		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		46,151,425		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-29,827		70.93
70.94	HRR adjustment amount (see instructions)		-43,814		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/27/2015 6:07 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		6,657		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		46,071,127		71.00
71.01	Sequestration adjustment (see instructions)		921,423		71.01
72.00	Interim payments		45,384,692		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)		-234,988		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		2,126,227		75.00
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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 6:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		28,263	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,958,331	2.00
3.00	PPS payments		10,900,747	3.00
4.00	Outlier payment (see instructions)		67,113	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		57,929	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		28,263	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		111,847	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)		111,847	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 charge basis 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)		111,847	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		83,584	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)		28,263	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)		11,025,789	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)		2,549,392	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)		8,504,660	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		7,792	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)		8,512,452	30.00
31.00	Primary payer payments		2,474	31.00
32.00	Subtotal (line 30 minus line 31)		8,509,978	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)		130,685	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		84,945	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		114,733	36.00
37.00	Subtotal (see instructions)		8,594,923	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-160	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)		8,595,083	40.00
40.01	Sequestration adjustment (see instructions)		171,902	40.01
41.00	Interim payments		8,545,236	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-122,055	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: 150169 Component CCN: 15S169	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 6:07 pm
		Title XVIIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			588 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			95 2.00
3.00	PPS payments			366 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			1 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			588 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			2,321 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)			2,321 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 charge basis 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)			2,321 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			1,733 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)			588 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)			367 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)			955 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)			955 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			955 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)			955 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)			955 40.00
40.01	Sequestration adjustment (see instructions)			19 40.01
41.00	Interim payments			814 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			122 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: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2015 6:07 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		45,276,892		8,466,036	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/01/2014	107,800	08/01/2014	79,200	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)		107,800		79,200	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)		45,384,692		8,545,236	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		234,988		122,055	6.02
7.00	Total Medicare program liability (see instructions)		45,149,704		8,423,181	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: 150169
Component CCN: 15S169

Period:
From 01/01/2014
To 12/31/2014

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2015 6:07 pm
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
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		2,140,091		814	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)		2,140,091		814	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		8,628		122	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,148,719		936	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: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet E-1
Part II
Date/Time Prepared:
5/27/2015 6:07 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	13,677	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	20,548	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	6,432	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	68,373	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,048,287,429	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	5,395,821	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)	893,461	8.00
9.00	Sequestration adjustment amount (see instructions)	17,869	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	875,592	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	871,219	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	4,373	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150169 Component CCN: 15S169	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/27/2015 6:07 pm
		Title XVIIII	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)			2,353,144 1.00
2.00	Net IPF PPS Outlier Payments			41,773 2.00
3.00	Net IPF PPS ECT Payments			7,302 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 instructions)			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 instructions)			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)			8.547945 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			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)			2,402,219 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)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,402,219 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,402,219 18.00
19.00	Deductibles			217,536 19.00
20.00	Subtotal (line 18 minus line 19)			2,184,683 20.00
21.00	Coinsurance			912 21.00
22.00	Subtotal (line 20 minus line 21)			2,183,771 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			941 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			612 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			-458 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,184,383 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)			8,187 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)			2,192,570 31.00
31.01	Sequestration adjustment (see instructions)			43,851 31.01
32.00	Interim payments			2,140,091 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)			8,628 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			41,773 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/27/2015 6:07 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			1.68	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			1.68	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			1.89	6.00
7.00	Enter the lesser of line 5 or line 6			1.68	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	1.89	0.00	1.89	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	1.68	0.00	1.68	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	1.68	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.38	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.19	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	1.42	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	1.42	0.00		17.00
18.00	Per resident amount	80,383.66	0.00		18.00
19.00	Approved amount for resident costs	114,145	0	114,145	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.21	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			114,145	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	23,181	6,432		26.00
27.00	Total Inpatient Days (see instructions)	72,793	72,793		27.00
28.00	Ratio of inpatient days to total inpatient days	0.318451	0.088360		28.00
29.00	Program direct GME amount	36,350	10,086		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		1,425		30.00
31.00	Net Program direct GME amount			45,011	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/27/2015 6:07 pm
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,989,829	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		52,774,516	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		26,896	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		52,747,620	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		11,045,207	42.00
43.00	Primary payer payments (see instructions)		2,474	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		11,042,733	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		63,790,353	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.826890	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.173110	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		45,011	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		37,219	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		7,792	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet G

Date/Time Prepared:
5/27/2015 6:07 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	1,562,257	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	226,641,968	0	0	0	4.00
5.00	Other receivable	1,056,477	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-175,362,612	0	0	0	6.00
7.00	Inventory	4,014,430	0	0	0	7.00
8.00	Prepaid expenses	16,454	0	0	0	8.00
9.00	Other current assets	0	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)	57,928,974	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,705,851	0	0	0	12.00
13.00	Land improvements	3,158,137	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	293,409,404	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	4,977,715	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,118,039	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	92,404,082	0	0	0	23.00
24.00	Accumulated depreciation	-199,684,624	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)	200,088,604	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	973,563,853	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	973,563,853	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,231,581,431	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	80,969	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	627,962	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	708,931	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	12,117,866	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,117,866	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,826,797	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,218,754,634	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,218,754,634	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,231,581,431	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet G-1

Date/Time Prepared:
5/27/2015 6:07 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		1,001,434,621		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		140,874,537			2.00
3.00	Total (sum of line 1 and line 2)		1,142,309,158		0	3.00
4.00	OTHER FUND BALANCE ACTIVITY	76,446,438		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		76,446,438		0	10.00
11.00	Subtotal (line 3 plus line 10)		1,218,755,596		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		1,218,755,596		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	OTHER FUND BALANCE ACTIVITY		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: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2015 6:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	140,152,596		140,152,596	1.00
2.00	SUBPROVIDER - IPF	-1,230		-1,230	2.00
3.00	SUBPROVIDER - IRF	5,821,480		5,821,480	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	145,972,846		145,972,846	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	18,239,409		18,239,409	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	NEONATAL INTENSIVE CARE UNIT	73,923,693		73,923,693	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	92,163,102		92,163,102	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	238,135,948		238,135,948	17.00
18.00	Ancillary services	419,674,781	423,839,788	843,514,569	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	657,810,729	423,839,788	1,081,650,517	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		325,973,671		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)		325,973,671		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150169

Period:
From 01/01/2014
To 12/31/2014

Worksheet G-3

Date/Time Prepared:
5/27/2015 6:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,081,650,517	1.00
2.00	Less contractual allowances and discounts on patients' accounts	674,196,742	2.00
3.00	Net patient revenues (line 1 minus line 2)	407,453,775	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	325,973,671	4.00
5.00	Net income from service to patients (line 3 minus line 4)	81,480,104	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	35,017,333	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	8,591	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	4,974	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	4,389,891	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	19,973,644	24.00
25.00	Total other income (sum of lines 6-24)	59,394,433	25.00
26.00	Total (line 5 plus line 25)	140,874,537	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	140,874,537	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150169	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/27/2015 6:07 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,114,950	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		266,679	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)		196.41	3.00
4.00	Number of interns & residents (see instructions)		1.09	4.00
5.00	Indirect medical education percentage (see instructions)		0.16	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		4,984	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.36	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		24.98	8.00
9.00	Sum of lines 7 and 8		28.34	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.91	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		184,094	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		3,570,707	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