

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: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/28/2015 3:57 pm
--	----------------------	---	--

PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/28/2015 Time: 3:57 pm	
	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.		
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 HENDRICKS REGIONAL HEALTH (150005) 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	218,375	114,264	0	5,909	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	218,375	114,264	0	5,909	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: 150005		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 3:55 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1000 EAST MAIN STREET			PO Box:							1.00	
2.00	City: DANVILLE			State: IN		Zip Code: 46122-1409		County: HENDRICKS			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
								V	XVIII	XIX		
3.00	Hospital and Hospital-Based Component Identification:											
	Hospital		HENDRICKS REGIONAL HEALTH	150005	26900	1	07/01/1966	N	P	O	3.00	
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2014	12/31/2014		20.00		
21.00	Type of Control (see instructions)						2		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N	23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	920	673	0	0	1,613	0		24.00			
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 3:55 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	N			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.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 3:55 pm			
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00	61.20		
				1.00			
<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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted 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: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 3:55 pm		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	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: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 3:55 pm	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 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:	847,310	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: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 3:55 pm	
		1.00	2.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
		1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y			145.00
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	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	165.00
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
		4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.00
					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.			N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 3:55 pm
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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)			171.00
			N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/28/2015 3:55 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/02/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150005

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

Worksheet S-2
Part II
Date/Time Prepared:
5/28/2015 3:55 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		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			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959		MALESSANDRI NI@BLUEANDCO.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)	02/02/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150005

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2015 3:55 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	112	40,880	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)		112	40,880	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		124	45,260	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		124				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: 150005

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2015 3:55 pm

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)	6,778	901	15,859			1.00
2.00 HMO and other (see instructions)	2,249	2,145				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)	6,778	901	15,859			7.00
8.00 INTENSIVE CARE UNIT	997	0	2,001			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	2,851			13.00
14.00 Total (see instructions)	7,775	901	20,711	0.00	1,258.36	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,258.36	27.00
28.00 Observation Bed Days		0	3,350			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	160	385			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: 150005

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2015 3:55 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	1,840	242	4,964	1.00
2.00 HMO and other (see instructions)			529	649		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,840	242	4,964	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150005		Period: From 01/01/2014 To 12/31/2014		Worksheet S-3 Part II Date/Time Prepared: 5/28/2015 3:55 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	87,128,917	0	87,128,917	2,617,379.00	33.29	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)		27,438,924	-133,956	27,304,968	562,149.00	48.57	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		990,433	0	990,433	16,955.00	58.42	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		260,019	0	260,019	2,907.00	89.45	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		16,779,280	0	16,779,280			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		5,576,994	0	5,576,994			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	-73,537	1,054,242	980,705	32,591.00	30.09	26.00
27.00	Administrative & General	5.00	7,338,910	-110,181	7,228,729	245,009.00	29.50	27.00
28.00	Administrative & General under contract (see inst.)		3,610,414	0	3,610,414	17,488.00	206.45	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,276,884	-37,208	2,239,676	94,827.00	23.62	30.00
31.00	Laundry & Linen Service	8.00	274,554	-3,134	271,420	19,895.00	13.64	31.00
32.00	Housekeeping	9.00	1,752,551	-27,599	1,724,952	124,576.00	13.85	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,526,358	-1,151,054	375,304	23,191.00	16.18	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,124,574	1,124,574	71,918.00	15.64	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,740,821	-27,734	1,713,087	59,686.00	28.70	38.00
39.00	Central Services and Supply	14.00	603,733	-9,431	594,302	28,614.00	20.77	39.00
40.00	Pharmacy	15.00	1,972,193	-30,664	1,941,529	52,576.00	36.93	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150005

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

Worksheet S-3
Part II
Date/Time Prepared:
5/28/2015 3:55 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es 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 1,276,608	-21,887	1,254,721	58,037.00	21.62	41.00
42.00	Social Service	17.00 1,728,174	-26,272	1,701,902	49,279.00	34.54	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150005

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

Worksheet S-3
Part III
Date/Time Prepared:
5/28/2015 3:55 pm

	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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	90,739,331	0	90,739,331	2,634,867.00	34.44	1.00
2.00	Excluded area salaries (see instructions)	27,438,924	-133,956	27,304,968	562,149.00	48.57	2.00
3.00	Subtotal salaries (line 1 minus line 2)	63,300,407	133,956	63,434,363	2,072,718.00	30.60	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,250,452	0	1,250,452	19,862.00	62.96	4.00
5.00	Subtotal wage-related costs (see inst.)	16,779,280	0	16,779,280	0.00	26.45	5.00
6.00	Total (sum of lines 3 thru 5)	81,330,139	133,956	81,464,095	2,092,580.00	38.93	6.00
7.00	Total overhead cost (see instructions)	24,027,663	733,652	24,761,315	877,687.00	28.21	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2015 3:55 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		-51,015	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		10,389,694	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		-183,137	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)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		128,009	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		4,169,996	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		28,465	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))		2,152,590	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		144,678	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		16,779,280	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: 150005

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

Worksheet S-3
Part V
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			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: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/28/2015 3:55 pm
---	--	----------------------	---	--

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.328312		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,405,557		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		27,670,431		6.00
7.00	Medicaid cost (line 1 times line 6)		9,084,535		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		4,678,978		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,678,978		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	4,200,000	0	4,200,000	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,378,910	0	1,378,910	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,378,910	0	1,378,910	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		19,787,191		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		270,832		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		19,516,359		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		6,407,455		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,786,365		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		12,465,343		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150005

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

Worksheet A
Date/Time Prepared:
5/28/2015 3:55 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	NEW CAP REL COSTS-BLDG & FIXT		19,414,649		19,414,649	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-73,537	273,996	200,459	1,067,144	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,338,910	29,040,382	36,379,292	-20,185	5.00
7.00	00700	OPERATION OF PLANT	2,276,884	4,685,736	6,962,620	-25,764	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	274,554	321,211	595,765	50,073	8.00
9.00	00900	HOUSEKEEPING	1,752,551	1,105,702	2,858,253	-27,603	9.00
10.00	01000	DIETARY	1,526,358	1,737,059	3,263,417	-2,431,169	10.00
11.00	01100	CAFETERIA	0	0	0	2,404,386	11.00
13.00	01300	NURSING ADMINISTRATION	1,740,821	774,919	2,515,740	-28,374	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	603,733	863,941	1,467,674	-193,836	14.00
15.00	01500	PHARMACY	1,972,193	8,270,865	10,243,058	-6,407,558	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,276,608	944,401	2,221,009	-21,889	16.00
17.00	01700	SOCIAL SERVICE	1,728,174	792,246	2,520,420	-21,821	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,847,588	4,126,433	14,974,021	-580,603	30.00
31.00	03100	INTENSIVE CARE UNIT	1,898,783	953,241	2,852,024	-263,309	31.00
43.00	04300	NURSERY	266,735	157,232	423,967	-59,660	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,535,095	6,963,551	8,498,646	2,598,813	50.00
50.01	05001	ENDOSCOPY	826,576	563,842	1,390,418	-209,931	50.01
51.00	05100	RECOVERY ROOM	1,196,558	509,036	1,705,594	-127,294	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	995,919	179,606	1,175,525	-35,473	52.00
53.00	05300	ANESTHESIOLOGY	942,737	1,185,207	2,127,944	-167,766	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,684,899	3,370,528	7,055,427	-299,120	54.00
54.01	05401	RADIATION-ONCOLOGY	945,509	10,533,250	11,478,759	-45,472	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	160,993	205,145	366,138	-3,477	56.00
59.00	05900	CARDIAC CATHETERIZATION	526,851	1,148,028	1,674,879	-1,567,348	59.00
60.00	06000	LABORATORY	2,447,200	4,639,350	7,086,550	-15,009	60.00
64.00	06400	INTRAVENOUS THERAPY	947,626	340,844	1,288,470	-13,556	64.00
65.00	06500	RESPIRATORY THERAPY	1,626,132	861,167	2,487,299	-91,348	65.00
66.00	06600	PHYSICAL THERAPY	3,875,645	1,834,224	5,709,869	-137,338	66.00
67.00	06700	OCCUPATIONAL THERAPY	304,344	102,997	407,341	-570	67.00
68.00	06800	SPEECH PATHOLOGY	370,145	121,491	491,636	-5,809	68.00
69.00	06900	ELECTROCARDIOLOGY	471,562	369,490	841,052	-14,735	69.00
69.01	06901	CARDIAC REHAB	371,356	125,339	496,695	-8,933	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	102,326	48,278	150,604	-2,142	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,132,236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,315,950	73.00
73.01	07301	ULTRA SOUND	474,657	171,050	645,707	-57,432	73.01
74.00	07400	RENAL DIALYSIS	0	95,708	95,708	-1,392	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,502,632	3,788,259	5,290,891	-371,655	90.00
91.00	09100	EMERGENCY	2,950,876	1,952,163	4,903,039	-323,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,689,993	112,570,566	172,260,559	987,779	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,125,842	14,882,889	38,008,731	-873,383	192.00
192.01	19201	HEALTH TRACKS	2,764,914	1,059,950	3,824,864	-56,081	192.01
194.00	07950	PRIMARY CARE CLINIC	375,230	312,306	687,536	-3,417	194.00
194.01	07951	PARTNERS IN CARE	595,730	267,607	863,337	-39,832	194.01
194.02	07952	OCCUPATIONAL MEDICINE	182,939	590,917	773,856	-10,670	194.02
194.03	07953	FOUNDATION	144,048	50,843	194,891	-2,188	194.03
194.04	07954	SCHOOL & TOWN CLINICS	250,221	36,116	286,337	-2,208	194.04
200.00		TOTAL (SUM OF LINES 118-199)	87,128,917	129,771,194	216,900,111	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150005

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

Worksheet A
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-876,918	18,537,731	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-67,436	1,200,167	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-15,141,602	21,217,505	5.00
7.00	00700	OPERATION OF PLANT	0	6,936,856	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-35,720	610,118	8.00
9.00	00900	HOUSEKEEPING	0	2,830,650	9.00
10.00	01000	DIETARY	-428,647	403,601	10.00
11.00	01100	CAFETERIA	-789,324	1,615,062	11.00
13.00	01300	NURSING ADMINISTRATION	-12,382	2,474,984	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-3,506	1,270,332	14.00
15.00	01500	PHARMACY	0	3,835,500	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,579	2,190,541	16.00
17.00	01700	SOCIAL SERVICE	0	2,498,599	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,154,653	12,238,765	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,588,715	31.00
43.00	04300	NURSERY	-35	364,272	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,097,459	50.00
50.01	05001	ENDOSCOPY	0	1,180,487	50.01
51.00	05100	RECOVERY ROOM	0	1,578,300	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,140,052	52.00
53.00	05300	ANESTHESIOLOGY	-1,466,316	493,862	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-115,237	6,641,070	54.00
54.01	05401	RADIATION-ONCOLOGY	0	11,433,287	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	362,661	56.00
59.00	05900	CARDIAC CATHETERIZATION	-32	107,499	59.00
60.00	06000	LABORATORY	-4,142	7,067,399	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,274,914	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,395,951	65.00
66.00	06600	PHYSICAL THERAPY	-413,046	5,159,485	66.00
67.00	06700	OCCUPATIONAL THERAPY	-40,348	366,423	67.00
68.00	06800	SPEECH PATHOLOGY	0	485,827	68.00
69.00	06900	ELECTROCARDIOLOGY	-116,756	709,561	69.00
69.01	06901	CARDIAC REHAB	0	487,762	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	148,462	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,132,236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,600	6,314,350	73.00
73.01	07301	ULTRA SOUND	0	588,275	73.01
74.00	07400	RENAL DIALYSIS	0	94,316	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-141,703	4,777,533	90.00
91.00	09100	EMERGENCY	-431,149	4,148,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-22,249,131	150,999,207	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	37,135,348	192.00
192.01	19201	HEALTH TRACKS	0	3,768,783	192.01
194.00	07950	PRIMARY CARE CLINIC	0	684,119	194.00
194.01	07951	PARTNERS IN CARE	0	823,505	194.01
194.02	07952	OCCUPATIONAL MEDICINE	0	763,186	194.02
194.03	07953	FOUNDATION	0	192,703	194.03
194.04	07954	SCHOOL & TOWN CLINICS	0	284,129	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-22,249,131	194,650,980	200.00

RECLASSIFICATIONS

Provider CCN: 150005

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

Worksheet A-6
Date/Time Prepared:
5/28/2015 3:55 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,315,950	1.00
2.00	INTRAVENOUS THERAPY	64.00	0	51,938	2.00
	0		0	6,367,888	
B - MOB PLANT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13,919	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	90,077	2.00
3.00	OPERATION OF PLANT	7.00	0	11,462	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	53,207	4.00
5.00	SOCIAL SERVICE	17.00	0	4,451	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	99,914	6.00
7.00	LABORATORY	60.00	0	29,505	7.00
8.00	PHYSICAL THERAPY	66.00	0	63,643	8.00
9.00	OCCUPATIONAL THERAPY	67.00	0	7,076	9.00
10.00	CLINIC	90.00	0	217,221	10.00
	0		0	590,475	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	1,124,574	1,279,812	1.00
	0		1,124,574	1,279,812	
D - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,132,236	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
	0		0	2,132,236	
E - BONUS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,054,242	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
	0		1,054,242	0	
F - MEDICAL SUPPLY RECLASS					
1.00	OPERATING ROOM	50.00	0	3,222,688	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

Provider CCN: 150005

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

Worksheet A-6

Date/Time Prepared:
5/28/2015 3:55 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
			0	3,222,688		
500.00	Grand Total: Increases		2,178,816	13,593,099		500.00

RECLASSIFICATIONS

Provider CCN: 150005

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

Worksheet A-6
Date/Time Prepared:
5/28/2015 3:55 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - DRUG RECLASS							
1.00	PHARMACY	15.00	0	6,367,888	0		1.00
2.00		0.00	0	0	0		2.00
	O			6,367,888			
B - MOB PLANT RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	590,475	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	O			590,475			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	1,124,574	1,279,812	0		1.00
	O		1,124,574	1,279,812			
D - IMPLANTABLE DEVICES							
1.00	OPERATING ROOM	50.00	0	598,290	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	80,153	0		2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	889,794	0		3.00
4.00	RENAL DIALYSIS	74.00	0	1,392	0		4.00
5.00	CLINIC	90.00	0	562,546	0		5.00
6.00	EMERGENCY	91.00	0	61	0		6.00
	O			2,132,236			
E - BONUS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	110,181	0	0		1.00
2.00	OPERATION OF PLANT	7.00	37,208	0	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	3,134	0	0		3.00
4.00	HOUSEKEEPING	9.00	27,599	0	0		4.00
5.00	DIETARY	10.00	26,480	0	0		5.00
6.00	NURSING ADMINISTRATION	13.00	27,734	0	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	9,431	0	0		7.00
8.00	PHARMACY	15.00	30,664	0	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	21,887	0	0		9.00
10.00	SOCIAL SERVICE	17.00	26,272	0	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	168,695	0	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	30,312	0	0		12.00
13.00	OPERATING ROOM	50.00	25,585	0	0		13.00
14.00	ENDOSCOPY	50.01	13,383	0	0		14.00
15.00	RECOVERY ROOM	51.00	21,259	0	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	63,721	0	0		16.00
17.00	RADIATION-ONCOLOGY	54.01	16,445	0	0		17.00
18.00	NUCLEAR MEDICINE - DIAGNOSTIC	56.00	3,477	0	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	9,069	0	0		19.00
20.00	LABORATORY	60.00	41,965	0	0		20.00
21.00	INTRAVENOUS THERAPY	64.00	15,313	0	0		21.00
22.00	RESPIRATORY THERAPY	65.00	19,532	0	0		22.00
23.00	PHYSICAL THERAPY	66.00	57,217	0	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	4,576	0	0		24.00
25.00	SPEECH PATHOLOGY	68.00	5,806	0	0		25.00
26.00	ELECTROCARDIOLOGY	69.00	11,646	0	0		26.00
27.00	CARDIAC REHAB	69.01	6,073	0	0		27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	2,126	0	0		28.00
29.00	ULTRA SOUND	73.01	7,999	0	0		29.00
30.00	CLINIC	90.00	26,326	0	0		30.00
31.00	EMERGENCY	91.00	49,171	0	0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	88,186	0	0		32.00
33.00	HEALTH TRACKS	192.01	26,445	0	0		33.00
34.00	PRIMARY CARE CLINIC	194.00	3,409	0	0		34.00
35.00	PARTNERS IN CARE	194.01	9,082	0	0		35.00
36.00	OCCUPATIONAL MEDICINE	194.02	3,398	0	0		36.00
37.00	FOUNDATION	194.03	2,188	0	0		37.00
38.00	SCHOOL & TOWN CLINICS	194.04	1,248	0	0		38.00
	O		1,054,242	0			
F - MEDICAL SUPPLY RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,017	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	81	0		2.00
3.00	OPERATION OF PLANT	7.00	0	18	0		3.00
4.00	HOUSEKEEPING	9.00	0	4	0		4.00
5.00	DIETARY	10.00	0	303	0		5.00

RECLASSIFICATIONS

Provider CCN: 150005

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

Worksheet A-6

Date/Time Prepared:
5/28/2015 3:55 pm

		Decreases			Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
6.00	NURSING ADMINISTRATION	13.00	0	640	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	184,405	0		7.00
8.00	PHARMACY	15.00	0	9,006	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	2	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	411,908	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	232,997	0		11.00
12.00	NURSERY	43.00	0	59,660	0		12.00
13.00	ENDOSCOPY	50.01	0	196,548	0		13.00
14.00	RECOVERY ROOM	51.00	0	106,035	0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	35,473	0		15.00
16.00	ANESTHESIOLOGY	53.00	0	167,766	0		16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	255,160	0		17.00
18.00	RADIATION-ONCOLOGY	54.01	0	29,027	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	668,485	0		19.00
20.00	LABORATORY	60.00	0	2,549	0		20.00
21.00	INTRAVENOUS THERAPY	64.00	0	50,181	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	71,816	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	143,764	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	3,070	0		24.00
25.00	SPEECH PATHOLOGY	68.00	0	3	0		25.00
26.00	ELECTROCARDIOLOGY	69.00	0	3,089	0		26.00
27.00	CARDIAC REHAB	69.01	0	2,860	0		27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	16	0		28.00
29.00	ULTRA SOUND	73.01	0	49,433	0		29.00
30.00	CLINIC	90.00	0	4	0		30.00
31.00	EMERGENCY	91.00	0	274,020	0		31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	194,722	0		32.00
33.00	HEALTH TRACKS	192.01	0	29,636	0		33.00
34.00	PRIMARY CARE CLINIC	194.00	0	8	0		34.00
35.00	PARTNERS IN CARE	194.01	0	30,750	0		35.00
36.00	OCCUPATIONAL MEDICINE	194.02	0	7,272	0		36.00
37.00	SCHOOL & TOWN CLINICS	194.04	0	960	0		37.00
	0		0	3,222,688			
500.00	Grand Total: Decreases		2,178,816	13,593,099			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150005

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

Worksheet A-7
Part I
Date/Time Prepared:
5/28/2015 3:55 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	16,307,701	100,001	0	100,001	0	1.00
2.00	Land Improvements	6,010,567	163,570	0	163,570	0	2.00
3.00	Buildings and Fixtures	245,289,973	2,680,518	0	2,680,518	393,837	3.00
4.00	Building Improvements	331,097	408,185	0	408,185	275,784	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	74,559,661	7,509,934	0	7,509,934	9,068,377	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	342,498,999	10,862,208	0	10,862,208	9,737,998	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	342,498,999	10,862,208	0	10,862,208	9,737,998	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	16,407,702	0				1.00
2.00	Land Improvements	6,174,137	0				2.00
3.00	Buildings and Fixtures	247,576,654	0				3.00
4.00	Building Improvements	463,498	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	73,001,218	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	343,623,209	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	343,623,209	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150005

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	13,921,590	0	5,350,629	142,430	0	1.00
3.00	Total (sum of lines 1-2)	13,921,590	0	5,350,629	142,430	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	19,414,649				1.00
3.00	Total (sum of lines 1-2)	0	19,414,649				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150005

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

Worksheet A-7
Part III
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	19,414,649	0	19,414,649	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	19,414,649	0	19,414,649	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	13,910,861	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	13,910,861	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,484,440	142,430	0	0	18,537,731	1.00
3.00	Total (sum of lines 1-2)	4,484,440	142,430	0	0	18,537,731	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150005

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

Worksheet A-8

Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
			Cost Center				
			1.00	2.00			
1.00	B	-866,189	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
2.00		0	*** Cost Center Deleted ***		2.00	0	2.00
3.00		0			0.00	0	3.00
4.00		0			0.00	0	4.00
5.00		0			0.00	0	5.00
6.00		0			0.00	0	6.00
7.00		0			0.00	0	7.00
8.00		0			0.00	0	8.00
9.00		0			0.00	0	9.00
10.00	A-8-2	-4,537,528				0	10.00
11.00		0			0.00	0	11.00
12.00	A-8-1	0				0	12.00
13.00		0			0.00	0	13.00
14.00	A	-785,343	CAFETERIA		11.00	0	14.00
15.00		0			0.00	0	15.00
16.00		0			0.00	0	16.00
17.00		0			0.00	0	17.00
18.00		0			0.00	0	18.00
19.00		0			0.00	0	19.00
20.00		0			0.00	0	20.00
21.00		0			0.00	0	21.00
22.00		0			0.00	0	22.00
23.00	A-8-3	0	RESPIRATORY THERAPY		65.00		23.00
24.00	A-8-3	0	PHYSICAL THERAPY		66.00		24.00
25.00		0	*** Cost Center Deleted ***		114.00		25.00
26.00		0	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
27.00		0	*** Cost Center Deleted ***		2.00	0	27.00
28.00		0	*** Cost Center Deleted ***		19.00		28.00
29.00		0			0.00	0	29.00
30.00	A-8-3	0	OCCUPATIONAL THERAPY		67.00		30.00
30.99		0	ADULTS & PEDIATRICS		30.00		30.99
31.00	A-8-3	0	SPEECH PATHOLOGY		68.00		31.00
32.00		0			0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150005

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

Worksheet A-8

Date/Time Prepared:
5/28/2015 3:55 pm

33.00	ADMITTING TELEPHONE (EQUIPMENT)	A	-14,850	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			0	33.00		
				Basis/Code (2)	Amount	Cost Center			Line #	Wkst. A-7 Ref.
				ADMINISTRATIVE & GENERAL	5.00					
33.01	ADMITTING TELEPHONE (SALARY)	A	-58,550	ADMINISTRATIVE & GENERAL	5.00		0 33.01			
33.02	MARKETING DEPARTMENT	A	-2,078,967	ADMINISTRATIVE & GENERAL	5.00		0 33.02			
34.00	STAFF EDUCATION ED DEPT COURSES	B	-10,615	NURSING ADMINISTRATION	13.00		0 34.00			
35.00	CBC - OB UNIT ED DEPT COURSES	B	-9,910	ADULTS & PEDIATRICS	30.00		0 35.00			
36.00	EMS PROGRAM ED DEPT COURSES	B	-31,698	EMERGENCY	91.00		0 36.00			
37.00	LABORATORY MISC. SERVICES	B	-4,142	LABORATORY	60.00		0 37.00			
38.00	RADIOLOGY MISC./OTHER	B	-43,876	RADIOLOGY-DIAGNOSTIC	54.00		0 38.00			
39.00	RADIOLOGY SALE OF X-RAYS	B	-2,760	RADIOLOGY-DIAGNOSTIC	54.00		0 39.00			
40.00	PHYSICAL THERAPY SUPPLIES SOLD TO OT	B	-7,257	PHYSICAL THERAPY	66.00		0 40.00			
41.00	SPORTS MEDICINE ED DEPT. COURSES	B	-39,022	PHYSICAL THERAPY	66.00		0 41.00			
43.00	PLAINFIELD PT SUPPLIES SOLD TO OTHER	B	-12,541	PHYSICAL THERAPY	66.00		0 43.00			
44.00	DIETARY CATERING	B	-3,981	CAFETERIA	11.00		0 44.00			
45.00	REGISTRATION ANSWERING SERVICE	B	-3,980	ADMINISTRATIVE & GENERAL	5.00		0 45.00			
45.01	ACCOUNTING MISCELLANEOUS/OTHER	B	16,984	ADMINISTRATIVE & GENERAL	5.00		0 45.01			
45.02	ACCOUNTING PURCHASE DISCOUNTS TAKEN	B	-71,187	ADMINISTRATIVE & GENERAL	5.00		0 45.02			
45.03	GUEST ROOM RENTAL	B	-480	ADMINISTRATIVE & GENERAL	5.00		0 45.03			
45.04	HEALTH INFO MGMT MEDICAL RECORDS TRA	B	-3,773	MEDICAL RECORDS & LIBRARY	16.00		0 45.04			
45.05	HEALTH INFO MGMT TRANSCRIPTION SERVI	B	-4,806	MEDICAL RECORDS & LIBRARY	16.00		0 45.05			
45.06	HUMAN RESOURCES JURY DUTY RECEIPTS	B	-180	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 45.06			
45.07	MATERIALS MGMT. SUPPLIES SOLD TO OTH	B	-3,506	CENTRAL SERVICES & SUPPLY	14.00		0 45.07			
45.08	PLAINFIELD PT ED DEPT COURSES	B	50	PHYSICAL THERAPY	66.00		0 45.08			
45.09	AVON ORTH/SPORT MISC./OTHER	B	-431	PHYSICAL THERAPY	66.00		0 45.09			
45.10	OCC THERAPY REHAB SUPPLIES SOLD TO O	B	-34	OCCUPATIONAL THERAPY	67.00		0 45.10			
45.11	HUMAN RESOURCES ED DEPT COURSES	B	-30	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 45.11			
45.12	ECHO MISCELLANEOUS	B	-1,200	ELECTROCARDIOLOGY	69.00		0 45.12			
45.13	LAUNDRY MISCELLANEOUS	B	-35,720	LAUNDRY & LINEN SERVICE	8.00		0 45.13			
45.14	HRH WELLNESS ED DEPARTMENT COURSES	B	-67,226	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 45.14			
45.15	MARKETING ED DEPT COURSES	B	-2,825	ADMINISTRATIVE & GENERAL	5.00		0 45.15			
45.16	MEALS ON WHEELS	A	-428,647	DIETARY	10.00		0 45.16			
45.17	1993 CARRYFORWARD	A	-14,017	NEW CAP REL COSTS-BLDG & FIXT	1.00		9 45.17			
45.21	1994 CARRYFORWARD	A	3,288	NEW CAP REL COSTS-BLDG & FIXT	1.00		9 45.21			
45.22	PHYSICIAN RECRUITMENT	A	-624,110	ADMINISTRATIVE & GENERAL	5.00		0 45.22			
45.24	IHA LOBBYING EXPENSE	A	-3,150	ADMINISTRATIVE & GENERAL	5.00		0 45.24			
45.25	AHA LOBBYING EXPENSE	A	-5,753	ADMINISTRATIVE & GENERAL	5.00		0 45.25			
45.28	HOSPITAL ASSESSMENT FEE	A	-12,058,688	ADMINISTRATIVE & GENERAL	5.00		0 45.28			
45.29	WOUND OSTOMY LEASE REVENUE	B	-348	PHYSICAL THERAPY	66.00		0 45.29			
45.30	PHARMACY SUPPLIES SOLD TO OTHERS	B	-1,600	DRUGS CHARGED TO PATIENTS	73.00		0 45.30			
45.31	B' BURG PT SUPPLIES SOLD T	B	-187	PHYSICAL THERAPY	66.00		0 45.31			
45.33	AVON PHYS THRYP SUPPLIES	B	-4,706	PHYSICAL THERAPY	66.00		0 45.33			
45.34	PHYSICAL THER ED DEPT COU	B	-5,775	PHYSICAL THERAPY	66.00		0 45.34			
45.35	OCC THER ED DEPT CO	B	-40,314	OCCUPATIONAL THERAPY	67.00		0 45.35			
45.36	ACCOUNTING NON-OP REVENUE CO	B	-36,680	ADMINISTRATIVE & GENERAL	5.00		0 45.36			
45.37	ACCOUNTING NON-OP REVENUE	B	-199,366	ADMINISTRATIVE & GENERAL	5.00		0 45.37			
45.38	NURS. ADMIN. ED DEPT COURSE	B	-1,767	NURSING ADMINISTRATION	13.00		0 45.38			
45.39	HIBBELN SUR CNT MISCELLANEOUS	B	-141,703	CLINIC	90.00		0 45.39			
45.40	NURSERY PICTURES	B	-35	NURSERY	43.00		0 45.40			
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-22,249,131				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.

Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8 Date/Time Prepared: 5/28/2015 3:55 pm
----------------------	---	---

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	5.00

(3) Additional adjustments may be made on lines 33 thru 49 and subscrip ts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150005

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2015 3:55 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2,144,743	2,144,743	0	177,200	0	1.00
2.00	91.00	EMERGENCY	85,675	0	85,675	177,200	1,006	2.00
3.00	91.00	EMERGENCY	104,990	0	104,990	177,200	1,232	3.00
4.00	60.00	LABORATORY	69,354	0	69,354	215,700	669	4.00
5.00	66.00	PHYSICAL THERAPY	342,829	342,829	0	177,200	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	115,556	115,556	0	177,200	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	138,129	0	138,129	177,200	1,621	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	68,601	68,601	0	177,200	0	8.00
9.00	91.00	EMERGENCY	399,418	399,418	0	177,200	0	9.00
10.00	53.00	ANESTHESIOLOGY	1,466,316	1,466,316	0	177,200	0	10.00
200.00			4,935,611	4,537,463	398,148		4,528	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	85,703	4,285	0	0	0	2.00
3.00	91.00	EMERGENCY	104,957	5,248	0	0	0	3.00
4.00	60.00	LABORATORY	69,377	3,469	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	59.00	CARDIAC CATHETERIZATION	138,097	6,905	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	10.00
200.00			398,134	19,907	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,144,743	1.00
2.00	91.00	EMERGENCY	0	85,703	0	0	2.00
3.00	91.00	EMERGENCY	0	104,957	33	33	3.00
4.00	60.00	LABORATORY	0	69,377	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	0	0	0	342,829	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	115,556	6.00
7.00	59.00	CARDIAC CATHETERIZATION	0	138,097	32	32	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	68,601	8.00
9.00	91.00	EMERGENCY	0	0	0	399,418	9.00
10.00	53.00	ANESTHESIOLOGY	0	0	0	1,466,316	10.00
200.00			0	398,134	65	4,537,528	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150005

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADM NI STRATI VE & GENERAL	
		RELATED COSTS				
		NEW BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	18,537,731	18,537,731			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,200,167	164,039	1,364,206		4.00
5.00 00500	ADM NI STRATI VE & GENERAL	21,217,505	1,670,558	114,474	23,002,537	5.00
7.00 00700	OPERATION OF PLANT	6,936,856	2,417,646	35,468	9,389,970	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	610,118	283,594	4,298	898,010	8.00
9.00 00900	HOUSEKEEPING	2,830,650	127,307	27,316	2,985,273	9.00
10.00 01000	DI ETARY	403,601	499,450	5,943	908,994	10.00
11.00 01100	CAFETERIA	1,615,062	88,698	17,809	1,721,569	11.00
13.00 01300	NURSI NG ADM NI STRATION	2,474,984	258,162	27,128	2,760,274	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,270,332	461,914	9,411	1,741,657	14.00
15.00 01500	PHARMACY	3,835,500	203,841	30,746	4,070,087	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,190,541	161,832	19,870	2,372,243	16.00
17.00 01700	SOCIAL SERVICE	2,498,599	27,906	26,951	2,553,456	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	12,238,765	2,083,457	169,111	14,491,333	30.00
31.00 03100	INTENSIVE CARE UNIT	2,588,715	262,694	29,589	2,880,998	31.00
43.00 04300	NURSERY	364,272	49,730	4,224	418,226	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,097,459	827,050	23,905	11,948,414	50.00
50.01 05001	ENDOSCOPY	1,180,487	160,520	12,878	1,353,885	50.01
51.00 05100	RECOVERY ROOM	1,578,300	486,421	18,612	2,083,333	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,140,052	168,660	15,771	1,324,483	52.00
53.00 05300	ANESTHESIOLOGY	493,862	0	14,929	508,791	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,641,070	916,463	57,345	7,614,878	54.00
54.01 05401	RADIATION-ONCOLOGY	11,433,287	403,120	14,713	11,851,120	54.01
56.00 03450	NUCLEAR MEDICINE - DIAGNOSTIC	362,661	15,712	2,494	380,867	56.00
59.00 05900	CARDIAC CATHETERIZATION	107,499	264,692	8,200	380,391	59.00
60.00 06000	LABORATORY	7,067,399	346,174	38,089	7,451,662	60.00
64.00 06400	INTRAVENOUS THERAPY	1,274,914	40,398	14,764	1,330,076	64.00
65.00 06500	RESPIRATORY THERAPY	2,395,951	189,440	25,442	2,610,833	65.00
66.00 06600	PHYSICAL THERAPY	5,159,485	589,430	60,469	5,809,384	66.00
67.00 06700	OCCUPATIONAL THERAPY	366,423	16,785	4,747	387,955	67.00
68.00 06800	SPEECH PATHOLOGY	485,827	70,809	5,770	562,406	68.00
69.00 06900	ELECTROCARDIOLOGY	709,561	124,803	7,283	841,647	69.00
69.01 06901	CARDIAC REHAB	487,762	146,090	5,785	639,637	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	148,462	79,962	1,587	230,011	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	2,132,236	0	0	2,132,236	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,314,350	0	0	6,314,350	73.00
73.01 07301	ULTRA SOUND	588,275	20,333	7,390	615,998	73.01
74.00 07400	RENAL DIALYSIS	94,316	0	0	94,316	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	4,777,533	601,177	23,379	5,402,089	90.00
91.00 09100	EMERGENCY	4,148,638	674,222	45,951	4,868,811	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	150,999,207	14,903,089	931,841	146,932,200	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	37,135,348	2,973,450	364,789	40,473,587	192.00
192.01 19201	HEALTH TRACKS	3,768,783	370,443	43,366	4,182,592	192.01
194.00 07950	PRIMARY CARE CLINIC	684,119	0	5,888	690,007	194.00
194.01 07951	PARTNERS IN CARE	823,505	118,393	9,290	951,188	194.01
194.02 07952	OCCUPATIONAL MEDICINE	763,186	141,111	2,843	907,140	194.02
194.03 07953	FOUNDATION	192,703	14,132	2,246	209,081	194.03
194.04 07954	SCHOOL & TOWN CLINICS	284,129	17,113	3,943	305,185	194.04
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118-201)	194,650,980	18,537,731	1,364,206	194,650,980	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150005

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	10,648,320				7.00
8.00	00800	LAUNDRY & LINEN SERVICE		1,018,352			8.00
9.00	00900	HOUSEKEEPING	157,408		3,542,737		9.00
10.00	01000	DIETARY	617,542			1,648,350	10.00
11.00	01100	CAFETERIA	109,670				11.00
13.00	01300	NURSING ADMINISTRATION	319,203				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	571,130	324	54,831		14.00
15.00	01500	PHARMACY	252,038	942	16,262		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	200,097				16.00
17.00	01700	SOCIAL SERVICE					17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,576,078	309,754	1,508,578	1,269,236	30.00
31.00	03100	INTENSIVE CARE UNIT	324,807	40,828	128,217	156,349	31.00
43.00	04300	NURSERY	61,489	13,544	11,467	222,765	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,022,601	68,329	122,796		50.00
50.01	05001	ENDOSCOPY	198,475	33,624	6,254		50.01
51.00	05100	RECOVERY ROOM	601,432	75,279	143,227		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	208,538	47,776	5,421		52.00
53.00	05300	ANESTHESIOLOGY			5,837		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	724,520	95,052	157,821		54.00
54.01	05401	RADIATION-ONCOLOGY		8,847	74,845		54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	19,427		6,463		56.00
59.00	05900	CARDIAC CATHETERIZATION	327,277				59.00
60.00	06000	LABORATORY	300,366	401	100,488		60.00
64.00	06400	INTRAVENOUS THERAPY	49,950	4,134	8,131		64.00
65.00	06500	RESPIRATORY THERAPY	234,232		13,134		65.00
66.00	06600	PHYSICAL THERAPY	275,077	62,931	102,156		66.00
67.00	06700	OCCUPATIONAL THERAPY			16,053		67.00
68.00	06800	SPEECH PATHOLOGY	87,551		6,463		68.00
69.00	06900	ELECTROCARDIOLOGY	154,312	15,028	88,813		69.00
69.01	06901	CARDIAC REHAB	108,969	343	17,304		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	98,869	603	35,233		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS					73.00
73.01	07301	ULTRA SOUND	25,141		7,297		73.01
74.00	07400	RENAL DIALYSIS		92	9,799		74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		64,927	144,895		90.00
91.00	09100	EMERGENCY	833,637	143,326	276,447		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				157,479	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,459,836	986,084	3,068,232	1,648,350	2,061,946
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	42,098	24,725	301,257		192.00
192.01	19201	HEALTH TRACKS		5,689	88,396		192.01
194.00	07950	PRIMARY CARE CLINIC			4,587		194.00
194.01	07951	PARTNERS IN CARE	146,386	872	24,184		194.01
194.02	07952	OCCUPATIONAL MEDICINE		942	54,205		194.02
194.03	07953	FOUNDATION					194.03
194.04	07954	SCHOOL & TOWN CLINICS		40	1,876		194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118-201)	10,648,320	1,018,352	3,542,737	1,648,350	2,061,946

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150005

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
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	3,531,941					13.00
14.00	01400	0	2,629,871				14.00
15.00	01500	0	0	4,972,060			15.00
16.00	01600	0	0	0	2,988,546		16.00
17.00	01700	0	0	0	0	2,927,896	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,349,335	2,629,871	0	281,710	1,790,267	30.00
31.00	03100	257,431	0	0	83,867	367,423	31.00
43.00	04300	32,652	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	228,796	0	0	0	20,642	50.00
50.01	05001	116,646	0	0	0	0	50.01
51.00	05100	139,167	0	0	97,934	0	51.00
52.00	05200	107,498	0	0	0	0	52.00
53.00	05300	27,185	0	0	0	0	53.00
54.00	05400	433,574	0	0	685,922	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	03450	0	0	0	0	0	56.00
59.00	05900	60,416	0	0	0	0	59.00
60.00	06000	0	0	0	840,939	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	242,009	0	0	50,848	0	65.00
66.00	06600	0	0	0	218,372	0	66.00
67.00	06700	0	0	0	23,336	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	96,797	0	0	148,218	0	69.00
69.01	06901	39,237	0	0	0	0	69.01
70.00	07000	0	0	0	0	0	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	4,972,060	0	0	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	401,198	0	0	557,400	749,564	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		3,531,941	2,629,871	4,972,060	2,988,546	2,927,896	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,531,941	2,629,871	4,972,060	2,988,546	2,927,896	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150005

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
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				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	28,677,788	0	28,677,788	30.00
31.00	03100	4,727,050	0	4,727,050	31.00
43.00	04300	829,006	0	829,006	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	15,102,592	0	15,102,592	50.00
50.01	05001	1,936,104	0	1,936,104	50.01
51.00	05100	3,474,185	0	3,474,185	51.00
52.00	05200	1,913,405	0	1,913,405	52.00
53.00	05300	620,667	0	620,667	53.00
54.00	05400	10,902,424	0	10,902,424	54.00
54.01	05401	13,572,107	0	13,572,107	54.01
56.00	03450	464,267	0	464,267	56.00
59.00	05900	842,775	0	842,775	59.00
60.00	06000	9,821,412	0	9,821,412	60.00
64.00	06400	1,611,932	0	1,611,932	64.00
65.00	06500	3,595,928	0	3,595,928	65.00
66.00	06600	7,312,403	0	7,312,403	66.00
67.00	06700	490,477	0	490,477	67.00
68.00	06800	750,436	0	750,436	68.00
69.00	06900	1,495,599	0	1,495,599	69.00
69.01	06901	906,609	0	906,609	69.01
70.00	07000	401,499	0	401,499	70.00
71.00	07100	0	0	0	71.00
72.00	07200	2,417,977	0	2,417,977	72.00
73.00	07300	12,132,596	0	12,132,596	73.00
73.01	07301	749,958	0	749,958	73.01
74.00	07400	116,846	0	116,846	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	6,335,845	0	6,335,845	90.00
91.00	09100	8,640,331	0	8,640,331	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00		139,842,218	0	139,842,218	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	46,265,463	0	46,265,463	192.00
192.01	19201	4,837,186	0	4,837,186	192.01
194.00	07950	787,062	0	787,062	194.00
194.01	07951	1,250,099	0	1,250,099	194.01
194.02	07952	1,083,853	0	1,083,853	194.02
194.03	07953	237,100	0	237,100	194.03
194.04	07954	347,999	0	347,999	194.04
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		194,650,980	0	194,650,980	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150005

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

Worksheet B Part II Date/Time Prepared: 5/28/2015 3:55 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	164,039	164,039	164,039		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,670,558	1,670,558	13,764	1,684,322	5.00
7.00 00700	OPERATION OF PLANT	0	2,417,646	2,417,646	4,264	92,144	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	283,594	283,594	517	8,812	8.00
9.00 00900	HOUSEKEEPING	0	127,307	127,307	3,284	29,294	9.00
10.00 01000	DIETARY	0	499,450	499,450	715	8,920	10.00
11.00 01100	CAFETERIA	0	88,698	88,698	2,141	16,894	11.00
13.00 01300	NURSING ADMINISTRATION	0	258,162	258,162	3,262	27,087	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	461,914	461,914	1,132	17,091	14.00
15.00 01500	PHARMACY	0	203,841	203,841	3,697	39,940	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	161,832	161,832	2,389	23,279	16.00
17.00 01700	SOCIAL SERVICE	0	27,906	27,906	3,240	25,057	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	2,083,457	2,083,457	20,333	142,203	30.00
31.00 03100	INTENSIVE CARE UNIT	0	262,694	262,694	3,558	28,271	31.00
43.00 04300	NURSERY	0	49,730	49,730	508	4,104	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	827,050	827,050	2,874	117,250	50.00
50.01 05001	ENDOSCOPY	0	160,520	160,520	1,548	13,286	50.01
51.00 05100	RECOVERY ROOM	0	486,421	486,421	2,238	20,444	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	168,660	168,660	1,896	12,997	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	1,795	4,993	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	916,463	916,463	6,895	74,725	54.00
54.01 05401	RADIATION-ONCOLOGY	0	403,120	403,120	1,769	116,295	54.01
56.00 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	15,712	15,712	300	3,737	56.00
59.00 05900	CARDIAC CATHETERIZATION	0	264,692	264,692	986	3,733	59.00
60.00 06000	LABORATORY	0	346,174	346,174	4,580	73,123	60.00
64.00 06400	INTRAVENOUS THERAPY	0	40,398	40,398	1,775	13,052	64.00
65.00 06500	RESPIRATORY THERAPY	0	189,440	189,440	3,059	25,620	65.00
66.00 06600	PHYSICAL THERAPY	0	589,430	589,430	7,270	57,007	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	16,785	16,785	571	3,807	67.00
68.00 06800	SPEECH PATHOLOGY	0	70,809	70,809	694	5,519	68.00
69.00 06900	ELECTROCARDIOLOGY	0	124,803	124,803	876	8,259	69.00
69.01 06901	CARDIAC REHAB	0	146,090	146,090	695	6,277	69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	79,962	79,962	191	2,257	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	20,924	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	61,963	73.00
73.01 07301	ULTRA SOUND	0	20,333	20,333	889	6,045	73.01
74.00 07400	RENAL DIALYSIS	0	0	0	0	926	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	601,177	601,177	2,811	53,011	90.00
91.00 09100	EMERGENCY	0	674,222	674,222	5,525	47,778	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	14,903,089	14,903,089	112,041	1,216,124	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	2,973,450	2,973,450	43,873	397,100	192.00
192.01 19201	HEALTH TRACKS	0	370,443	370,443	5,214	41,044	192.01
194.00 07950	PRIMARY CARE CLINIC	0	0	0	708	6,771	194.00
194.01 07951	PARTNERS IN CARE	0	118,393	118,393	1,117	9,334	194.01
194.02 07952	OCCUPATIONAL MEDICINE	0	141,111	141,111	342	8,902	194.02
194.03 07953	FOUNDATION	0	14,132	14,132	270	2,052	194.03
194.04 07954	SCHOOL & TOWN CLINICS	0	17,113	17,113	474	2,995	194.04
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	18,537,731	18,537,731	164,039	1,684,322	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/28/2015 3:55 pm				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	2,514,054				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	292,923			8.00	
9.00	00900	HOUSEKEEPING	37,164	0	197,049		9.00	
10.00	01000	DIETARY	145,801	0	0	654,886	10.00	
11.00	01100	CAFETERIA	25,893	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	75,363	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	134,843	93	3,050	0	14.00	
15.00	01500	PHARMACY	59,506	271	904	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	47,243	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	608,206	89,100	83,910	504,265	34,327	30.00
31.00	03100	INTENSIVE CARE UNIT	76,686	11,744	7,131	62,117	6,548	31.00
43.00	04300	NURSERY	14,517	3,896	638	88,504	831	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	241,435	19,654	6,830	0	5,820	50.00
50.01	05001	ENDOSCOPY	46,860	9,672	348	0	2,967	50.01
51.00	05100	RECOVERY ROOM	141,997	21,654	7,966	0	3,540	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	49,236	13,742	301	0	2,734	52.00
53.00	05300	ANESTHESIOLOGY	0	0	325	0	692	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,058	27,341	8,778	0	11,029	54.00
54.01	05401	RADIATION-ONCOLOGY	0	2,545	4,163	0	3,184	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	4,587	0	359	0	419	56.00
59.00	05900	CARDIAC CATHETERIZATION	77,270	0	0	0	1,537	59.00
60.00	06000	LABORATORY	70,916	115	5,589	0	8,357	60.00
64.00	06400	INTRAVENOUS THERAPY	11,793	1,189	452	0	2,683	64.00
65.00	06500	RESPIRATORY THERAPY	55,302	0	731	0	6,156	65.00
66.00	06600	PHYSICAL THERAPY	64,945	18,102	5,682	0	4,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	893	0	722	67.00
68.00	06800	SPEECH PATHOLOGY	20,671	0	359	0	1,209	68.00
69.00	06900	ELECTROCARDIOLOGY	36,433	4,323	4,940	0	2,462	69.00
69.01	06901	CARDIAC REHAB	25,728	99	962	0	998	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	23,343	173	1,960	0	386	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ULTRA SOUND	5,936	0	406	0	1,229	73.01
74.00	07400	RENAL DIALYSIS	0	26	545	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	18,676	8,059	0	0	90.00
91.00	09100	EMERGENCY	196,821	41,227	15,376	0	10,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,469,553	283,642	170,657	654,886	133,626	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,939	7,112	16,756	0	0	192.00
192.01	19201	HEALTH TRACKS	0	1,636	4,917	0	0	192.01
194.00	07950	PRIMARY CARE CLINIC	0	0	255	0	0	194.00
194.01	07951	PARTNERS IN CARE	34,562	251	1,345	0	0	194.01
194.02	07952	OCCUPATIONAL MEDICINE	0	271	3,015	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	SCHOOL & TOWN CLINICS	0	11	104	0	0	194.04
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)	2,514,054	292,923	197,049	654,886	133,626	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/28/2015 3:55 pm
-------------------------------------	--	----------------------	---	--

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
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	369,224					13.00
14.00	01400	0	619,972				14.00
15.00	01500	0	0	313,816			15.00
16.00	01600	0	0	0	241,113		16.00
17.00	01700	0	0	0	0	58,293	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	141,058	619,972	0	22,731	35,644	30.00
31.00	03100	26,911	0	0	6,767	7,315	31.00
43.00	04300	3,413	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	23,918	0	0	0	411	50.00
50.01	05001	12,194	0	0	0	0	50.01
51.00	05100	14,548	0	0	7,902	0	51.00
52.00	05200	11,238	0	0	0	0	52.00
53.00	05300	2,842	0	0	0	0	53.00
54.00	05400	45,325	0	0	55,346	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	03450	0	0	0	0	0	56.00
59.00	05900	6,316	0	0	0	0	59.00
60.00	06000	0	0	0	67,826	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	25,299	0	0	4,103	0	65.00
66.00	06600	0	0	0	17,620	0	66.00
67.00	06700	0	0	0	1,883	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	10,119	0	0	11,959	0	69.00
69.01	06901	4,102	0	0	0	0	69.01
70.00	07000	0	0	0	0	0	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	313,816	0	0	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	41,941	0	0	44,976	14,923	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		369,224	619,972	313,816	241,113	58,293	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		369,224	619,972	313,816	241,113	58,293	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/28/2015 3:55 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00 00500	ADMINISTRATIVE & GENERAL			5.00
7.00 00700	OPERATION OF PLANT			7.00
8.00 00800	LAUNDRY & LINEN SERVICE			8.00
9.00 00900	HOUSEKEEPING			9.00
10.00 01000	DIETARY			10.00
11.00 01100	CAFETERIA			11.00
13.00 01300	NURSING ADMINISTRATION			13.00
14.00 01400	CENTRAL SERVICES & SUPPLY			14.00
15.00 01500	PHARMACY			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY			16.00
17.00 01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	4,385,206	0	4,385,206 30.00
31.00 03100	INTENSIVE CARE UNIT	499,742	0	499,742 31.00
43.00 04300	NURSERY	166,141	0	166,141 43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	1,245,242	0	1,245,242 50.00
50.01 05001	ENDOSCOPY	247,395	0	247,395 50.01
51.00 05100	RECOVERY ROOM	706,710	0	706,710 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	260,804	0	260,804 52.00
53.00 05300	ANESTHESIOLOGY	10,647	0	10,647 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,316,960	0	1,316,960 54.00
54.01 05401	RADIATION-ONCOLOGY	531,076	0	531,076 54.01
56.00 03450	NUCLEAR MEDICINE - DIAGNOSTIC	25,114	0	25,114 56.00
59.00 05900	CARDIAC CATHETERIZATION	354,534	0	354,534 59.00
60.00 06000	LABORATORY	576,680	0	576,680 60.00
64.00 06400	INTRAVENOUS THERAPY	71,342	0	71,342 64.00
65.00 06500	RESPIRATORY THERAPY	309,710	0	309,710 65.00
66.00 06600	PHYSICAL THERAPY	764,331	0	764,331 66.00
67.00 06700	OCCUPATIONAL THERAPY	24,661	0	24,661 67.00
68.00 06800	SPEECH PATHOLOGY	99,261	0	99,261 68.00
69.00 06900	ELECTROCARDIOLOGY	204,174	0	204,174 69.00
69.01 06901	CARDIAC REHAB	184,951	0	184,951 69.01
70.00 07000	ELECTROENCEPHALOGRAPHY	108,272	0	108,272 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	20,924	0	20,924 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	375,779	0	375,779 73.00
73.01 07301	ULTRA SOUND	34,838	0	34,838 73.01
74.00 07400	RENAL DIALYSIS	1,497	0	1,497 74.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	683,734	0	683,734 90.00
91.00 09100	EMERGENCY	1,092,994	0	1,092,994 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,302,719	0	14,302,719 118.00
NONREIMBURSABLE COST CENTERS				
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,448,230	0	3,448,230 192.00
192.01 19201	HEALTH TRACKS	423,254	0	423,254 192.01
194.00 07950	PRIMARY CARE CLINIC	7,734	0	7,734 194.00
194.01 07951	PARTNERS IN CARE	165,002	0	165,002 194.01
194.02 07952	OCCUPATIONAL MEDICINE	153,641	0	153,641 194.02
194.03 07953	FOUNDATION	16,454	0	16,454 194.03
194.04 07954	SCHOOL & TOWN CLINICS	20,697	0	20,697 194.04
200.00	Cross Foot Adjustments	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	18,537,731	0	18,537,731 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150005

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

Worksheet B-1
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00		4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	621,772						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	5,502		86,148,212				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	56,032		7,228,729	-23,002,537	171,648,443		5.00
7.00 00700 OPERATION OF PLANT	81,090		2,239,676	0	9,389,970	288,856	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	9,512		271,420	0	898,010	0	8.00
9.00 00900 HOUSEKEEPING	4,270		1,724,952	0	2,985,273	4,270	9.00
10.00 01000 DIETARY	16,752		375,304	0	908,994	16,752	10.00
11.00 01100 CAFETERIA	2,975		1,124,574	0	1,721,569	2,975	11.00
13.00 01300 NURSING ADMINISTRATION	8,659		1,713,087	0	2,760,274	8,659	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	15,493		594,302	0	1,741,657	15,493	14.00
15.00 01500 PHARMACY	6,837		1,941,529	0	4,070,087	6,837	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	5,428		1,254,721	0	2,372,243	5,428	16.00
17.00 01700 SOCIAL SERVICE	936		1,701,902	0	2,553,456	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	69,881		10,678,893	0	14,491,333	69,881	30.00
31.00 03100 INTENSIVE CARE UNIT	8,811		1,868,471	0	2,880,998	8,811	31.00
43.00 04300 NURSERY	1,668		266,735	0	418,226	1,668	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	27,740		1,509,510	0	11,948,414	27,740	50.00
50.01 05001 ENDOSCOPY	5,384		813,193	0	1,353,885	5,384	50.01
51.00 05100 RECOVERY ROOM	16,315		1,175,299	0	2,083,333	16,315	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5,657		995,919	0	1,324,483	5,657	52.00
53.00 05300 ANESTHESIOLOGY	0		942,737	0	508,791	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	30,739		3,621,178	0	7,614,878	19,654	54.00
54.01 05401 RADIOLOGY-ONCOLOGY	13,521		929,064	0	11,851,120	0	54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	527		157,516	0	380,867	527	56.00
59.00 05900 CARDIAC CATHETERIZATION	8,878		517,782	0	380,391	8,878	59.00
60.00 06000 LABORATORY	11,611		2,405,235	0	7,451,662	8,148	60.00
64.00 06400 INTRAVENOUS THERAPY	1,355		932,313	0	1,330,076	1,355	64.00
65.00 06500 RESPIRATORY THERAPY	6,354		1,606,600	0	2,610,833	6,354	65.00
66.00 06600 PHYSICAL THERAPY	19,770		3,818,428	0	5,809,384	7,462	66.00
67.00 06700 OCCUPATIONAL THERAPY	563		299,768	0	387,955	0	67.00
68.00 06800 SPEECH PATHOLOGY	2,375		364,339	0	562,406	2,375	68.00
69.00 06900 ELECTROCARDIOLOGY	4,186		459,916	0	841,647	4,186	69.00
69.01 06901 CARDIAC REHAB	4,900		365,283	0	639,637	2,956	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	2,682		100,200	0	230,011	2,682	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		0	0	2,132,236	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	0	6,314,350	0	73.00
73.01 07301 ULTRA SOUND	682		466,658	0	615,998	682	73.01
74.00 07400 RENAL DIALYSIS	0		0	0	94,316	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	20,164		1,476,306	0	5,402,089	0	90.00
91.00 09100 EMERGENCY	22,614		2,901,705	0	4,868,811	22,614	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
SPECIAL PURPOSE COST CENTERS							
118.00 SUBTOTALS (SUM OF LINES 1-117)	499,863		58,843,244	-23,002,537	123,929,663	283,743	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	99,732		23,037,656	0	40,473,587	1,142	192.00
192.01 19201 HEALTH TRACKS	12,425		2,738,469	0	4,182,592	0	192.01
194.00 07950 PRIMARY CARE CLINIC	0		371,821	0	690,007	0	194.00
194.01 07951 PARTNERS IN CARE	3,971		586,648	0	951,188	3,971	194.01
194.02 07952 OCCUPATIONAL MEDICINE	4,733		179,541	0	907,140	0	194.02
194.03 07953 FOUNDATION	474		141,860	0	209,081	0	194.03
194.04 07954 SCHOOL & TOWN CLINICS	574		248,973	0	305,185	0	194.04
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)	18,537,731		1,364,206		23,002,537	10,648,320	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	29.814355		0.015836		0.134010	36.863766	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			164,039		1,684,322	2,514,054	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001904		0.009813	8.703485	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150005

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

Worksheet B-1

Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	822,918				8.00
9.00	00900	HOUSEKEEPING	0	16,993			9.00
10.00	01000	DIETARY	0	0	21,096		10.00
11.00	01100	CAFETERIA	0	0	0	1,217,368	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	48,743	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	262	263	0	16,844	0 14.00
15.00	01500	PHARMACY	761	78	0	51,541	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	58,037	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	19,041	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	250,309	7,236	16,244	312,700	312,700 30.00
31.00	03100	INTENSIVE CARE UNIT	32,993	615	2,001	59,658	59,658 31.00
43.00	04300	NURSERY	10,945	55	2,851	7,567	7,567 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	55,216	589	0	53,022	53,022 50.00
50.01	05001	ENDOSCOPY	27,171	30	0	27,032	27,032 50.01
51.00	05100	RECOVERY ROOM	60,832	687	0	32,251	32,251 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,607	26	0	24,912	24,912 52.00
53.00	05300	ANESTHESIOLOGY	0	28	0	6,300	6,300 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,810	757	0	100,478	100,478 54.00
54.01	05401	RADIATION-ONCOLOGY	7,149	359	0	29,004	0 54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	31	0	3,820	0 56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	14,001	14,001 59.00
60.00	06000	LABORATORY	324	482	0	76,137	0 60.00
64.00	06400	INTRAVENOUS THERAPY	3,341	39	0	24,441	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	63	0	56,084	56,084 65.00
66.00	06600	PHYSICAL THERAPY	50,854	490	0	38,947	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	77	0	6,579	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	31	0	11,010	0 68.00
69.00	06900	ELECTROCARDIOLOGY	12,144	426	0	22,432	22,432 69.00
69.01	06901	CARDIAC REHAB	277	83	0	9,093	9,093 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	487	169	0	3,518	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 PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
73.01	07301	ULTRA SOUND	0	35	0	11,201	0 73.01
74.00	07400	RENAL DIALYSIS	74	47	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	52,467	695	0	0	0 90.00
91.00	09100	EMERGENCY	115,820	1,326	0	92,975	92,975 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	796,843	14,717	21,096	1,217,368	818,505 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,980	1,445	0	0	0 192.00
192.01	19201	HEALTH TRACKS	4,597	424	0	0	0 192.01
194.00	07950	PRIMARY CARE CLINIC	0	22	0	0	0 194.00
194.01	07951	PARTNERS IN CARE	705	116	0	0	0 194.01
194.02	07952	OCCUPATIONAL MEDICINE	761	260	0	0	0 194.02
194.03	07953	FOUNDATION	0	0	0	0	0 194.03
194.04	07954	SCHOOL & TOWN CLINICS	32	9	0	0	0 194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,018,352	3,542,737	1,648,350	2,061,946	3,531,941 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.237489	208.482140	78.135666	1.693774	4.315112 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	292,923	197,049	654,886	133,626	369,224 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.355956	11.595892	31.043136	0.109766	0.451096 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150005

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

Worksheet B-1

Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
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	100				14.00
15.00	01500	0	100			15.00
16.00	01600	0	0	228,570,531		16.00
17.00	01700	0	0	0	16,312	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	100	0	21,545,709	9,974	30.00
31.00	03100	0	0	6,414,305	2,047	31.00
43.00	04300	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	0	0	115	50.00
50.01	05001	0	0	0	0	50.01
51.00	05100	0	0	7,490,160	0	51.00
52.00	05200	0	0	0	0	52.00
53.00	05300	0	0	0	0	53.00
54.00	05400	0	0	52,460,610	0	54.00
54.01	05401	0	0	0	0	54.01
56.00	03450	0	0	0	0	56.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	0	64,317,560	0	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	0	0	3,888,947	0	65.00
66.00	06600	0	0	16,701,467	0	66.00
67.00	06700	0	0	1,784,795	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	0	0	11,335,977	0	69.00
69.01	06901	0	0	0	0	69.01
70.00	07000	0	0	0	0	70.00
71.00	07100	0	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	100	0	0	73.00
73.01	07301	0	0	0	0	73.01
74.00	07400	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	0	42,631,001	4,176	91.00
92.00	09200	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		100	100	228,570,531	16,312	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	0	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
200.00						200.00
201.00						201.00
202.00		2,629,871	4,972,060	2,988,546	2,927,896	202.00
203.00		26,298.710000	49,720.600000	0.013075	179.493379	203.00
204.00		619,972	313,816	241,113	58,293	204.00
205.00		6,199.720000	3,138.160000	0.001055	3.573627	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150005

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2015 3:55 pm

		Title XVIIII		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	28,677,788		28,677,788	0	28,677,788	30.00
31.00	03100 INTENSIVE CARE UNIT	4,727,050		4,727,050	0	4,727,050	31.00
43.00	04300 NURSERY	829,006		829,006	0	829,006	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	15,102,592		15,102,592	0	15,102,592	50.00
50.01	05001 ENDOSCOPY	1,936,104		1,936,104	0	1,936,104	50.01
51.00	05100 RECOVERY ROOM	3,474,185		3,474,185	0	3,474,185	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,913,405		1,913,405	0	1,913,405	52.00
53.00	05300 ANESTHESIOLOGY	620,667		620,667	0	620,667	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,902,424		10,902,424	0	10,902,424	54.00
54.01	05401 RADIATION-ONCOLOGY	13,572,107		13,572,107	0	13,572,107	54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	464,267		464,267	0	464,267	56.00
59.00	05900 CARDIAC CATHETERIZATION	842,775		842,775	32	842,807	59.00
60.00	06000 LABORATORY	9,821,412		9,821,412	0	9,821,412	60.00
64.00	06400 INTRAVENOUS THERAPY	1,611,932		1,611,932	0	1,611,932	64.00
65.00	06500 RESPIRATORY THERAPY	3,595,928	0	3,595,928	0	3,595,928	65.00
66.00	06600 PHYSICAL THERAPY	7,312,403	0	7,312,403	0	7,312,403	66.00
67.00	06700 OCCUPATIONAL THERAPY	490,477	0	490,477	0	490,477	67.00
68.00	06800 SPEECH PATHOLOGY	750,436	0	750,436	0	750,436	68.00
69.00	06900 ELECTROCARDIOLOGY	1,495,599		1,495,599	0	1,495,599	69.00
69.01	06901 CARDIAC REHAB	906,609		906,609	0	906,609	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	401,499		401,499	0	401,499	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,417,977		2,417,977	0	2,417,977	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,132,596		12,132,596	0	12,132,596	73.00
73.01	07301 ULTRA SOUND	749,958		749,958	0	749,958	73.01
74.00	07400 RENAL DIALYSIS	116,846		116,846	0	116,846	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	6,335,845		6,335,845	0	6,335,845	90.00
91.00	09100 EMERGENCY	8,640,331		8,640,331	33	8,640,364	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,001,316		5,001,316		5,001,316	92.00
200.00	Subtotal (see instructions)	144,843,534	0	144,843,534	65	144,843,599	200.00
201.00	Less Observation Beds	5,001,316		5,001,316		5,001,316	201.00
202.00	Total (see instructions)	139,842,218	0	139,842,218	65	139,842,283	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/28/2015 3:55 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	21,537,313		21,537,313	30.00
31.00	03100	INTENSIVE CARE UNIT	6,195,550		6,195,550	31.00
43.00	04300	NURSERY	5,518,569		5,518,569	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,062,074	16,375,933	27,438,007	50.00
50.01	05001	ENDOSCOPY	476,460	9,565,372	10,041,832	50.01
51.00	05100	RECOVERY ROOM	2,089,135	5,401,025	7,490,160	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,785,238	140,701	7,925,939	52.00
53.00	05300	ANESTHESIOLOGY	4,746,332	5,966,109	10,712,441	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,730,899	45,419,149	52,150,048	54.00
54.01	05401	RADIATION-ONCOLOGY	267,772	38,587,334	38,855,106	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	240,292	3,247,313	3,487,605	56.00
59.00	05900	CARDIAC CATHETERIZATION	2,592,933	7,485,490	10,078,423	59.00
60.00	06000	LABORATORY	13,939,910	53,449,747	67,389,657	60.00
64.00	06400	INTRAVENOUS THERAPY	410,060	5,813,006	6,223,066	64.00
65.00	06500	RESPIRATORY THERAPY	2,687,521	1,200,165	3,887,686	65.00
66.00	06600	PHYSICAL THERAPY	1,883,263	14,797,393	16,680,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	782,420	914,309	1,696,729	67.00
68.00	06800	SPEECH PATHOLOGY	174,094	1,029,843	1,203,937	68.00
69.00	06900	ELECTROCARDIOLOGY	2,019,367	9,251,827	11,271,194	69.00
69.01	06901	CARDIAC REHAB	30,480	1,013,968	1,044,448	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	83,152	399,977	483,129	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,967,937	3,537,383	10,505,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,231,101	13,132,343	22,363,444	73.00
73.01	07301	ULTRA SOUND	1,607,232	7,007,710	8,614,942	73.01
74.00	07400	RENAL DIALYSIS	280,304	7,579	287,883	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	45,873	26,800,195	26,846,068	90.00
91.00	09100	EMERGENCY	8,192,117	34,383,142	42,575,259	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,087	3,435,967	3,439,054	92.00
200.00		Subtotal (see instructions)	117,580,485	308,362,980	425,943,465	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	117,580,485	308,362,980	425,943,465	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/28/2015 3:55 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
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.550426		50.00
50.01	05001 ENDOSCOPY	0.192804		50.01
51.00	05100 RECOVERY ROOM	0.463833		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.241411		52.00
53.00	05300 ANESTHESIOLOGY	0.057939		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.209059		54.00
54.01	05401 RADIATION-ONCOLOGY	0.349300		54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.133119		56.00
59.00	05900 CARDIAC CATHETERIZATION	0.083625		59.00
60.00	06000 LABORATORY	0.145741		60.00
64.00	06400 INTRAVENOUS THERAPY	0.259025		64.00
65.00	06500 RESPIRATORY THERAPY	0.924953		65.00
66.00	06600 PHYSICAL THERAPY	0.438376		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289072		67.00
68.00	06800 SPEECH PATHOLOGY	0.623318		68.00
69.00	06900 ELECTROCARDIOLOGY	0.132692		69.00
69.01	06901 CARDIAC REHAB	0.868027		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.831039		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.230167		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.542519		73.00
73.01	07301 ULTRA SOUND	0.087053		73.01
74.00	07400 RENAL DIALYSIS	0.405880		74.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.236006		90.00
91.00	09100 EMERGENCY	0.202943		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.454271		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150005

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2015 3:55 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	28,677,788		28,677,788	0	28,677,788	30.00
31.00	03100 INTENSIVE CARE UNIT	4,727,050		4,727,050	0	4,727,050	31.00
43.00	04300 NURSERY	829,006		829,006	0	829,006	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	15,102,592		15,102,592	0	15,102,592	50.00
50.01	05001 ENDOSCOPY	1,936,104		1,936,104	0	1,936,104	50.01
51.00	05100 RECOVERY ROOM	3,474,185		3,474,185	0	3,474,185	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,913,405		1,913,405	0	1,913,405	52.00
53.00	05300 ANESTHESIOLOGY	620,667		620,667	0	620,667	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,902,424		10,902,424	0	10,902,424	54.00
54.01	05401 RADIOLOGY-ONCOLOGY	13,572,107		13,572,107	0	13,572,107	54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	464,267		464,267	0	464,267	56.00
59.00	05900 CARDIAC CATHETERIZATION	842,775		842,775	32	842,807	59.00
60.00	06000 LABORATORY	9,821,412		9,821,412	0	9,821,412	60.00
64.00	06400 INTRAVENOUS THERAPY	1,611,932		1,611,932	0	1,611,932	64.00
65.00	06500 RESPIRATORY THERAPY	3,595,928	0	3,595,928	0	3,595,928	65.00
66.00	06600 PHYSICAL THERAPY	7,312,403	0	7,312,403	0	7,312,403	66.00
67.00	06700 OCCUPATIONAL THERAPY	490,477	0	490,477	0	490,477	67.00
68.00	06800 SPEECH PATHOLOGY	750,436	0	750,436	0	750,436	68.00
69.00	06900 ELECTROCARDIOLOGY	1,495,599		1,495,599	0	1,495,599	69.00
69.01	06901 CARDIAC REHAB	906,609		906,609	0	906,609	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	401,499		401,499	0	401,499	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2,417,977		2,417,977	0	2,417,977	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,132,596		12,132,596	0	12,132,596	73.00
73.01	07301 ULTRA SOUND	749,958		749,958	0	749,958	73.01
74.00	07400 RENAL DIALYSIS	116,846		116,846	0	116,846	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	6,335,845		6,335,845	0	6,335,845	90.00
91.00	09100 EMERGENCY	8,640,331		8,640,331	33	8,640,364	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,001,316		5,001,316		5,001,316	92.00
200.00	Subtotal (see instructions)	144,843,534	0	144,843,534	65	144,843,599	200.00
201.00	Less Observation Beds	5,001,316		5,001,316		5,001,316	201.00
202.00	Total (see instructions)	139,842,218	0	139,842,218	65	139,842,283	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150005

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2015 3:55 pm

		Title XIX			Hospital	Cost	
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,537,313		21,537,313		30.00
31.00	03100	INTENSIVE CARE UNIT	6,195,550		6,195,550		31.00
43.00	04300	NURSERY	5,518,569		5,518,569		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,062,074	16,375,933	27,438,007	0.550426	50.00
50.01	05001	ENDOSCOPY	476,460	9,565,372	10,041,832	0.192804	50.01
51.00	05100	RECOVERY ROOM	2,089,135	5,401,025	7,490,160	0.463833	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,785,238	140,701	7,925,939	0.241411	52.00
53.00	05300	ANESTHESIOLOGY	4,746,332	5,966,109	10,712,441	0.057939	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,730,899	45,419,149	52,150,048	0.209059	54.00
54.01	05401	RADIATION-ONCOLOGY	267,772	38,587,334	38,855,106	0.349300	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	240,292	3,247,313	3,487,605	0.133119	56.00
59.00	05900	CARDIAC CATHETERIZATION	2,592,933	7,485,490	10,078,423	0.083622	59.00
60.00	06000	LABORATORY	13,939,910	53,449,747	67,389,657	0.145741	60.00
64.00	06400	INTRAVENOUS THERAPY	410,060	5,813,006	6,223,066	0.259025	64.00
65.00	06500	RESPIRATORY THERAPY	2,687,521	1,200,165	3,887,686	0.924953	65.00
66.00	06600	PHYSICAL THERAPY	1,883,263	14,797,393	16,680,656	0.438376	66.00
67.00	06700	OCCUPATIONAL THERAPY	782,420	914,309	1,696,729	0.289072	67.00
68.00	06800	SPEECH PATHOLOGY	174,094	1,029,843	1,203,937	0.623318	68.00
69.00	06900	ELECTROCARDIOLOGY	2,019,367	9,251,827	11,271,194	0.132692	69.00
69.01	06901	CARDIAC REHAB	30,480	1,013,968	1,044,448	0.868027	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	83,152	399,977	483,129	0.831039	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,967,937	3,537,383	10,505,320	0.230167	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,231,101	13,132,343	22,363,444	0.542519	73.00
73.01	07301	ULTRA SOUND	1,607,232	7,007,710	8,614,942	0.087053	73.01
74.00	07400	RENAL DIALYSIS	280,304	7,579	287,883	0.405880	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	45,873	26,800,195	26,846,068	0.236006	90.00
91.00	09100	EMERGENCY	8,192,117	34,383,142	42,575,259	0.202943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,087	3,435,967	3,439,054	1.454271	92.00
200.00		Subtotal (see instructions)	117,580,485	308,362,980	425,943,465		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	117,580,485	308,362,980	425,943,465		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/28/2015 3:55 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	05001 ENDOSCOPY	0.000000		50.01
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 RADIATION-ONCOLOGY	0.000000		54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		56.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301 ULTRA SOUND	0.000000		73.01
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150005		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/28/2015 3:55 pm	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	4,385,206	0	4,385,206	19,209	228.29	30.00
31.00	INTENSIVE CARE UNIT	499,742		499,742	2,001	249.75	31.00
43.00	NURSERY	166,141		166,141	2,851	58.27	43.00
200.00	Total (Lines 30-199)	5,051,089		5,051,089	24,061		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	6,778	1,547,350				
31.00	INTENSIVE CARE UNIT	997	249,001				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	7,775	1,796,351				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/28/2015 3:55 pm
--	--	----------------------	---	--

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 Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,245,242	27,438,007	0.045384	4,909,280	222,803	50.00
50.01	05001 ENDOSCOPY	247,395	10,041,832	0.024636	0	0	50.01
51.00	05100 RECOVERY ROOM	706,710	7,490,160	0.094352	912,819	86,126	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	260,804	7,925,939	0.032905	11,339	373	52.00
53.00	05300 ANESTHESIOLOGY	10,647	10,712,441	0.000994	1,261,095	1,254	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,316,960	52,150,048	0.025253	3,675,438	92,816	54.00
54.01	05401 RADIATION-ONCOLOGY	531,076	38,855,106	0.013668	128,912	1,762	54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	25,114	3,487,605	0.007201	103,099	742	56.00
59.00	05900 CARDIAC CATHETERIZATION	354,534	10,078,423	0.035178	1,171,817	41,222	59.00
60.00	06000 LABORATORY	576,680	67,389,657	0.008557	7,089,835	60,668	60.00
64.00	06400 INTRAVENOUS THERAPY	71,342	6,223,066	0.011464	229,720	2,634	64.00
65.00	06500 RESPIRATORY THERAPY	309,710	3,887,686	0.079664	1,165,204	92,825	65.00
66.00	06600 PHYSICAL THERAPY	764,331	16,680,656	0.045821	1,027,212	47,068	66.00
67.00	06700 OCCUPATIONAL THERAPY	24,661	1,696,729	0.014534	437,478	6,358	67.00
68.00	06800 SPEECH PATHOLOGY	99,261	1,203,937	0.082447	83,727	6,903	68.00
69.00	06900 ELECTROCARDIOLOGY	204,174	11,271,194	0.018115	1,108,418	20,079	69.00
69.01	06901 CARDIAC REHAB	184,951	1,044,448	0.177080	9,146	1,620	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	108,272	483,129	0.224106	38,845	8,705	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	20,924	10,505,320	0.001992	3,208,750	6,392	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	375,779	22,363,444	0.016803	4,297,561	72,212	73.00
73.01	07301 ULTRA SOUND	34,838	8,614,942	0.004044	483,065	1,954	73.01
74.00	07400 RENAL DIALYSIS	1,497	287,883	0.005200	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	683,734	26,846,068	0.025469	340	9	90.00
91.00	09100 EMERGENCY	1,092,994	42,575,259	0.025672	4,226,385	108,500	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	764,766	3,439,054	0.222377	0	0	92.00
200.00	Total (lines 50-199)	10,016,396	392,692,033		35,579,485	883,025	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150005		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/28/2015 3:55 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	PPS	
			1.00	2.00	3.00	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
						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
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	19,209	0.00	6,778	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,001	0.00	997	0		31.00
43.00	04300	NURSERY	2,851	0.00	0	0		43.00
200.00		Total (lines 30-199)	24,061		7,775	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150005

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05401	RADIATION-ONCOLOGY	0	0	0	0	0	0	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	0	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
73.01	07301	ULTRA SOUND	0	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150005

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2015 3:55 pm

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			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	27,438,007	0.000000	0.000000	4,909,280	50.00
50.01	05001	ENDOSCOPY	0	10,041,832	0.000000	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0	7,490,160	0.000000	0.000000	912,819	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,925,939	0.000000	0.000000	11,339	52.00
53.00	05300	ANESTHESIOLOGY	0	10,712,441	0.000000	0.000000	1,261,095	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,150,048	0.000000	0.000000	3,675,438	54.00
54.01	05401	RADIATION-ONCOLOGY	0	38,855,106	0.000000	0.000000	128,912	54.01
56.00	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	3,487,605	0.000000	0.000000	103,099	56.00
59.00	05900	CARDIAC CATHETERIZATION	0	10,078,423	0.000000	0.000000	1,171,817	59.00
60.00	06000	LABORATORY	0	67,389,657	0.000000	0.000000	7,089,835	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,223,066	0.000000	0.000000	229,720	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,887,686	0.000000	0.000000	1,165,204	65.00
66.00	06600	PHYSICAL THERAPY	0	16,680,656	0.000000	0.000000	1,027,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,696,729	0.000000	0.000000	437,478	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,203,937	0.000000	0.000000	83,727	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,271,194	0.000000	0.000000	1,108,418	69.00
69.01	06901	CARDIAC REHAB	0	1,044,448	0.000000	0.000000	9,146	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	483,129	0.000000	0.000000	38,845	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	10,505,320	0.000000	0.000000	3,208,750	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,363,444	0.000000	0.000000	4,297,561	73.00
73.01	07301	ULTRA SOUND	0	8,614,942	0.000000	0.000000	483,065	73.01
74.00	07400	RENAL DIALYSIS	0	287,883	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	26,846,068	0.000000	0.000000	340	90.00
91.00	09100	EMERGENCY	0	42,575,259	0.000000	0.000000	4,226,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,439,054	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	392,692,033			35,579,485	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/28/2015 3:55 pm
--	----------------------	---	--

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)	Hospital	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
50.00	05000 OPERATING ROOM	0	14,176,049	0		50.00
50.01	05001 ENDOSCOPY	0	0	0		50.01
51.00	05100 RECOVERY ROOM	0	302,952	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	206,850	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	11,304,416	0		54.00
54.01	05401 RADIATION-ONCOLOGY	0	14,287,261	0		54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	985,747	0		56.00
59.00	05900 CARDIAC CATHETERIZATION	0	1,914,543	0		59.00
60.00	06000 LABORATORY	0	4,270,804	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	2,143,548	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	285,656	0		65.00
66.00	06600 PHYSICAL THERAPY	0	189,236	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	19,371	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,673,956	0		69.00
69.01	06901 CARDIAC REHAB	0	383,962	0		69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	494,125	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,133,094	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,127,547	0		73.00
73.01	07301 ULTRASOUND	0	1,270,031	0		73.01
74.00	07400 RENAL DIALYSIS	0	1,442	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	26,410	0		90.00
91.00	09100 EMERGENCY	0	6,867,085	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,335,263	0		92.00
200.00	Total (lines 50-199)	0	67,399,348	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/28/2015 3:55 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	0.550426	14,176,049	0	0	7,802,866	50.00
50.01	05001 ENDOSCOPY	0.192804	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0.463833	302,952	0	0	140,519	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.241411	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.057939	206,850	0	0	11,985	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.209059	11,304,416	0	519	2,363,290	54.00
54.01	05401 RADIATION-ONCOLOGY	0.349300	14,287,261	0	8,911	4,990,540	54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.133119	985,747	0	0	131,222	56.00
59.00	05900 CARDIAC CATHETERIZATION	0.083622	1,914,543	0	0	160,098	59.00
60.00	06000 LABORATORY	0.145741	4,270,804	630	0	622,431	60.00
64.00	06400 INTRAVENOUS THERAPY	0.259025	2,143,548	0	0	555,233	64.00
65.00	06500 RESPIRATORY THERAPY	0.924953	285,656	0	0	264,218	65.00
66.00	06600 PHYSICAL THERAPY	0.438376	189,236	0	0	82,957	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289072	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.623318	19,371	0	0	12,074	68.00
69.00	06900 ELECTROCARDIOLOGY	0.132692	1,673,956	0	0	222,121	69.00
69.01	06901 CARDIAC REHAB	0.868027	383,962	0	0	333,289	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.831039	494,125	0	0	410,637	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.230167	1,133,094	0	0	260,801	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.542519	4,127,547	0	4,274	2,239,273	73.00
73.01	07301 ULTRA SOUND	0.087053	1,270,031	0	0	110,560	73.01
74.00	07400 RENAL DIALYSIS	0.405880	1,442	0	0	585	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.236006	26,410	0	0	6,233	90.00
91.00	09100 EMERGENCY	0.202943	6,867,085	0	0	1,393,627	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.454271	1,335,263	0	0	1,941,834	92.00
200.00	Subtotal (see instructions)		67,399,348	630	13,704	24,056,393	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)		67,399,348	630	13,704	24,056,393	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/28/2015 3:55 pm
	Title XVIII	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	0	0		50.00
50.01 05001 ENDOSCOPY	0	0		50.01
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	109		54.00
54.01 05401 RADIATION-ONCOLOGY	0	3,113		54.01
56.00 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		56.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	92	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
69.01 06901 CARDIAC REHAB	0	0		69.01
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 PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,319		73.00
73.01 07301 ULTRA SOUND	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	92	5,541		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	92	5,541		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2015 3:55 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)		19,209	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,209	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)		15,859	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)		6,778	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)		28,677,788	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)		28,677,788	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)		28,677,788	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,492.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,119,080	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)		10,119,080	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150005		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/28/2015 3:55 pm	
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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	4,727,050	2,001	2,362.34	997	2,355,253		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					11,083,225		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					23,557,558		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,796,351		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					883,025		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,679,376		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,878,182		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)					3,350		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,492.93		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					5,001,316		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150005		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/28/2015 3:55 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)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,385,206	28,677,788	0.152913	5,001,316	764,766	90.00
91.00	Nursing School cost	0	28,677,788	0.000000	5,001,316	0	91.00
92.00	Allied health cost	0	28,677,788	0.000000	5,001,316	0	92.00
93.00	All other Medical Education	0	28,677,788	0.000000	5,001,316	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 5/28/2015 3:55 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,209	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,209	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)		15,859	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)		901	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)		2,851	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)		28,677,788	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)		28,677,788	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)		28,677,788	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,492.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,345,130	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)		1,345,130	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150005		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
Date/Time Prepared: 5/28/2015 3:55 pm		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	829,006	2,851	290.78	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	4,727,050	2,001	2,362.34	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 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					766,464	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,111,594	0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00	0	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	0	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	0	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)						3,350	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,492.93	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						5,001,316	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150005		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/28/2015 3:55 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)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,385,206	28,677,788	0.152913	5,001,316	764,766	90.00
91.00	Nursing School cost	0	28,677,788	0.000000	5,001,316	0	91.00
92.00	Allied health cost	0	28,677,788	0.000000	5,001,316	0	92.00
93.00	All other Medical Education	0	28,677,788	0.000000	5,001,316	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/28/2015 3:55 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		6,739,621		30.00
31.00	03100 INTENSIVE CARE UNIT		2,999,779		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.550426	4,909,280	2,702,195	50.00
50.01	05001 ENDOSCOPY	0.192804	0	0	50.01
51.00	05100 RECOVERY ROOM	0.463833	912,819	423,396	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.241411	11,339	2,737	52.00
53.00	05300 ANESTHESIOLOGY	0.057939	1,261,095	73,067	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.209059	3,675,438	768,383	54.00
54.01	05401 RADIOLOGY-ONCOLOGY	0.349300	128,912	45,029	54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.133119	103,099	13,724	56.00
59.00	05900 CARDIAC CATHETERIZATION	0.083625	1,171,817	97,993	59.00
60.00	06000 LABORATORY	0.145741	7,089,835	1,033,280	60.00
64.00	06400 INTRAVENOUS THERAPY	0.259025	229,720	59,503	64.00
65.00	06500 RESPIRATORY THERAPY	0.924953	1,165,204	1,077,759	65.00
66.00	06600 PHYSICAL THERAPY	0.438376	1,027,212	450,305	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289072	437,478	126,463	67.00
68.00	06800 SPEECH PATHOLOGY	0.623318	83,727	52,189	68.00
69.00	06900 ELECTROCARDIOLOGY	0.132692	1,108,418	147,078	69.00
69.01	06901 CARDIAC REHAB	0.868027	9,146	7,939	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.831039	38,845	32,282	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.230167	3,208,750	738,548	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.542519	4,297,561	2,331,508	73.00
73.01	07301 ULTRA SOUND	0.087053	483,065	42,052	73.01
74.00	07400 RENAL DIALYSIS	0.405880	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.236006	340	80	90.00
91.00	09100 EMERGENCY	0.202943	4,226,385	857,715	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.454271	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		35,579,485	11,083,225	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)		35,579,485		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/28/2015 3:55 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		977,537		30.00
31.00	03100 INTENSIVE CARE UNIT		109,085		31.00
43.00	04300 NURSERY		232,589		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.550426	179,168	98,619	50.00
50.01	05001 ENDOSCOPY	0.192804	3,398	655	50.01
51.00	05100 RECOVERY ROOM	0.463833	31,235	14,488	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.241411	1,335,991	322,523	52.00
53.00	05300 ANESTHESIOLOGY	0.057939	75,211	4,358	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.209059	109,240	22,838	54.00
54.01	05401 RADIATION-ONCOLOGY	0.349300	0	0	54.01
56.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0.133119	11,322	1,507	56.00
59.00	05900 CARDIAC CATHETERIZATION	0.083622	0	0	59.00
60.00	06000 LABORATORY	0.145741	411,193	59,928	60.00
64.00	06400 INTRAVENOUS THERAPY	0.259025	34,335	8,894	64.00
65.00	06500 RESPIRATORY THERAPY	0.924953	28,541	26,399	65.00
66.00	06600 PHYSICAL THERAPY	0.438376	32,377	14,193	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.289072	9,266	2,679	67.00
68.00	06800 SPEECH PATHOLOGY	0.623318	1,203	750	68.00
69.00	06900 ELECTROCARDIOLOGY	0.132692	71,738	9,519	69.00
69.01	06901 CARDIAC REHAB	0.868027	366	318	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.831039	610	507	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.230167	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.542519	250,407	135,851	73.00
73.01	07301 ULTRA SOUND	0.087053	60,989	5,309	73.01
74.00	07400 RENAL DIALYSIS	0.405880	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.236006	1,637	386	90.00
91.00	09100 EMERGENCY	0.202943	181,052	36,743	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.454271	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,829,279	766,464	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)		2,829,279		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/28/2015 3:55 pm
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		10,564,797	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,841,741	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)		345,991	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		114.82	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.52	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.20	31.00
32.00	Sum of lines 30 and 31		16.72	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.66	33.00
34.00	Disproportionate share adjustment (see instructions)		131,820	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/28/2015 3:55 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)		0.000100824	0.000095657	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		912,094	731,549	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		682,196	184,391	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		866,587		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)		15,750,936		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		15,750,936		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,256,896		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		17,007,832		59.00
60.00	Primary payer payments		86,400		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,921,432		61.00
62.00	Deductibles billed to program beneficiaries		1,744,352		62.00
63.00	Coinurance billed to program beneficiaries		8,512		63.00
64.00	Allowable bad debts (see instructions)		120,964		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		78,627		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,954		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,247,195		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)		28,132		70.93
70.94	HRR adjustment amount (see instructions)		-3,458		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/28/2015 3:55 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)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		15,271,869		71.00
71.01	Sequestration adjustment (see instructions)		305,437		71.01
72.00	Interim payments		14,748,057		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)		218,375		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,675,424		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150005

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2015 3:55 pm

		Title XVIII		Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,564,797	0	10,564,797	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,841,741	0	0	3,841,741	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	345,991	0	265,567	80,424	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0366	0.0366	0.0366	0.0366	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	131,820	0	96,668	35,152	11.00
11.01	Uncompensated care payments	36.00	866,587	0	682,196	184,391	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,750,936	0	11,609,228	4,141,708	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,750,936	0	11,609,228	4,141,708	15.00
16.00	Payment for inpatient program capital	50.00	1,256,896	0	925,430	331,466	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150005

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/28/2015 3:55 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	12,534,658	4,473,174	17,007,832	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,151,753	0	844,463	307,290	1,151,753	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	65,408	0	51,834	13,574	65,408	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0345	0.0345	0.0345	0.0345		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	39,735	0	29,133	10,602	39,735	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,256,896	0	925,430	331,466	1,256,896	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 150005		Period: From 01/01/2014 To 12/31/2014		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/28/2015 3:55 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,564,797	10,564,797		10,564,797	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,841,741		3,841,741	3,841,741	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	345,991	265,567	80,424	345,991	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0366	0.0366	0.0366		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	131,820	96,668	35,152	131,820	11.00
11.01	Uncompensated care payments	36.00	866,587	682,196	184,391	866,587	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,750,936	11,609,228	4,141,708	15,750,936	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,750,936	11,609,228	4,141,708	15,750,936	15.00
16.00	Payment for inpatient program capital	50.00	1,256,896	925,430	331,466	1,256,896	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			12,534,658	4,473,174	17,007,832	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 150005

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/28/2015 3:55 pm

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	1,151,753	844,463	307,290	1,151,753	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	65,408	51,834	13,574	65,408	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0345	0.0345	0.0345		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	39,735	29,133	10,602	39,735	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	1,256,896	925,430	331,466	1,256,896	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	28,132	21,668	6,464	28,132	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-3,458	0	-3,458	-3,458	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 3:55 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,633	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		24,056,393	2.00
3.00	PPS payments		14,889,918	3.00
4.00	Outlier payment (see instructions)		102,030	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,633	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		14,334	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		14,334	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)		14,334	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		8,701	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)		5,633	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)		14,991,948	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)		3,275,377	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)		11,722,204	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)		11,722,204	30.00
31.00	Primary payer payments		6,898	31.00
32.00	Subtotal (line 30 minus line 31)		11,715,306	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)		295,700	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		192,205	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		99,230	36.00
37.00	Subtotal (see instructions)		11,907,511	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-22	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)		11,907,533	40.00
40.01	Sequestration adjustment (see instructions)		238,151	40.01
41.00	Interim payments		11,555,118	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		114,264	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: 150005

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2015 3:55 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		14,748,057		11,477,282	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	12/31/2014	77,836	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		77,836	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)		14,748,057		11,555,118	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		218,375		114,264	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		14,966,432		11,669,382	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: 150005

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

Worksheet E-1
Part II
Date/Time Prepared:
5/28/2015 3:55 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			4,964 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			7,775 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2,249 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			17,860 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			425,943,465 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			4,200,000 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2015 3:55 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,111,594		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,111,594	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,111,594	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		1,319,210		8.00
9.00	Ancillary service charges		2,829,279	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		4,148,489	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		4,148,489	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,036,895	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,111,594	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		2,111,594	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,111,594	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2,111,594	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		2,111,594	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		2,111,594	0	40.00
41.00	Interim payments		2,105,685	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		5,909	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 150005

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

Worksheet G

Date/Time Prepared:
5/28/2015 3:55 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	5,307,840	0	0	0	1.00
2.00	Temporary investments	5,334,144	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	26,321,318	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,114,680	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	9,219,191	0	0	0	9.00
10.00	Due from other funds	4,680,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	52,977,173	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	196,541,014	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	196,541,014	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	159,430,416	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	4,030,400	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	163,460,816	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	412,979,003	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	6,228,147	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,512,333	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	4,680,000	0	0	0	43.00
44.00	Other current liabilities	12,215,092	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	31,635,572	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	106,562,019	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	106,562,019	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	138,197,591	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	274,781,412				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	274,781,412	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	412,979,003	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150005

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

Worksheet G-1

Date/Time Prepared:
5/28/2015 3:55 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		243,154,801		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		9,126,611			2.00
3.00	Total (sum of line 1 and line 2)		252,281,412		0	3.00
4.00	TRANSFERS FROM LTC	22,500,000		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)		22,500,000		0	10.00
11.00	Subtotal (line 3 plus line 10)		274,781,412		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)		274,781,412		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	TRANSFERS FROM LTC		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: 150005

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2015 3:55 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	27,055,882		27,055,882	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	27,055,882		27,055,882	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,195,550		6,195,550	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,195,550		6,195,550	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,251,432		33,251,432	17.00
18.00	Ancillary services	76,087,977	240,595,566	316,683,543	18.00
19.00	Outpatient services	8,241,077	64,695,348	72,936,425	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	PHYSICIANS' PRIVATE OFFICES	1,550,305	49,620,074	51,170,379	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	119,130,791	354,910,988	474,041,779	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		216,900,111		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)		216,900,111		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150005

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

Worksheet G-3

Date/Time Prepared:
5/28/2015 3:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	474,041,779	1.00
2.00	Less contractual allowances and discounts on patients' accounts	262,243,508	2.00
3.00	Net patient revenues (line 1 minus line 2)	211,798,271	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	216,900,111	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,101,840	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER AND NONOPERATING INCOME	14,228,451	24.00
25.00	Total other income (sum of lines 6-24)	14,228,451	25.00
26.00	Total (line 5 plus line 25)	9,126,611	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)	9,126,611	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150005	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/28/2015 3:55 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,151,753	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		65,408	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)		49.99	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		1.52	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		15.20	8.00
9.00	Sum of lines 7 and 8		16.72	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.45	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		39,735	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,256,896	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