

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).
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
 Provider CCN: 150097
 Period: From 01/01/2014 To 12/31/2014
 Worksheet 5
 Parts I-III
 Date/Time Prepared: 5/20/2015 1:38 pm

PART I - COST REPORT STATUS

Provider use only: 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.
 Contractor use only: 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date: _____
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.
 Date: 5/20/2015 Time: 1:38 pm

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 MAJOR HOSPITAL (150097) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/20/2015 Time: 1:38 pm
 aUI.tsiOf9Rxjgm:.99firFbtgHib0
 9HOLCO:YowizOuwjOzjmwXn3sdHXq
 IoDC1Hg3cN0dh4XZ
 PI: Date: 5/20/2015 Time: 1:38 pm
 4a.N606y.vBeQD5wzi3vv1E1uvccG00
 yNgKJ00nHr3Ts619v:FnpPrx6Stvkt
 rhen0ZUoda0.EakG

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

Title

Date

[Signature]
 CFO
 5-26-2015

	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	14,458	-61,954	-10,822	-774,624	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
9.00 HOME HEALTH AGENCY I	0	0	63		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
200.00 Total	0	14,458	-61,891	-10,822	-774,624	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: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/20/2015 1:28 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 150 WEST WASHINGTON ST		PO Box:						1.00			
2.00	City: SHELBYVILLE		State: IN		Zip Code: 46176-		County: IN		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			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		MAJOR HOSPITAL		150097	99915	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		MAJOR HOSPITAL		157418	99915		03/22/1995	N	P	N	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)					N		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.					748	585	0	0	663	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.					0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/20/2015 1:28 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)	Y		Y		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		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		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		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		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
			Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00	
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)					0 71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)					0 76.00	
						1.00	
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	

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		V		XIX			
		1.00		2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y			90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N			91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N			92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N			93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N			94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N					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		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N			110.00
						1.00 2.00 3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N			0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00
		Premiums 1.00		Losses 2.00		Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:		215,659	0			118.01
						1.00 2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/20/2015 1:28 pm	
		1.00	2.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:		Zip Code:	
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.		N	145.00	
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
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.			Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0
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)				0.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/20/2015 1:28 pm
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2014	12/31/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/20/2015 1:28 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
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	04/24/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
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		Legal Oper.	
		1.00	2.00	3.00	
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
		Y/N		Legal Oper.	
		1.00	2.00	3.00	
PS&R Data					
		Description	Part A		Part B
		0	Y/N	Date	Y/N
		1.00	2.00	3.00	
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	04/22/2015	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: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/20/2015 1:28 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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.			Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?	N			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@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)	04/22/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150097

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

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2015 1:28 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	52	18,980	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)		52	18,980	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	9	3,285	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						13.00
14.00 Total (see instructions)		61	22,265	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	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	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		61				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: 150097

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

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2015 1:28 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)	4,373	745	9,330			1.00
2.00 HMO and other (see instructions)	1,043	1,205				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)	4,373	745	9,330			7.00
8.00 INTENSIVE CARE UNIT	514	0	956			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)	4,887	745	10,286	0.00	563.95	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	8,146	406	10,427	0.00	10.93	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	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	574.88	27.00
28.00 Observation Bed Days		302	949			28.00
29.00 Ambulance Trips	639					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	46	72			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: 150097

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

Worksheet S-3
Part I
Date/Time Prepared:
5/20/2015 1:28 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	1,245	174	2,790	1.00
2.00 HMO and other (see instructions)			250	340		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	1,245	174	2,790	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					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	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					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: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet S-3 Part II Date/Time Prepared: 5/20/2015 1:28 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	35,517,316	0	35,517,316	1,182,203.00	30.04	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		380,326	0	380,326	2,086.00	182.32	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		2,553,985	0	2,553,985	13,997.00	182.47	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)		3,025,762	204,267	3,230,029	73,375.00	44.02	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		168,693	0	168,693	3,993.00	42.25	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		967,842	0	967,842	5,980.00	161.85	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)		9,022,424	0	9,022,424			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		717,696	0	717,696			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		68,500	0	68,500			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		231,485	0	231,485			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	528,565	0	528,565	9,929.00	53.23	26.00
27.00	Administrative & General	5.00	6,719,582	-204,267	6,515,315	212,349.00	30.68	27.00
28.00	Administrative & General under contract (see inst.)		512,062	0	512,062	2,996.00	170.92	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	754,273	0	754,273	31,321.00	24.08	30.00
31.00	Laundry & Linen Service	8.00	24,216	0	24,216	2,032.00	11.92	31.00
32.00	Housekeeping	9.00	715,946	0	715,946	54,317.00	13.18	32.00
33.00	Housekeeping under contract (see instructions)		186,180	0	186,180	2,261.00	82.34	33.00
34.00	Dietary	10.00	515,750	-352,305	163,445	11,894.00	13.74	34.00
35.00	Dietary under contract (see instructions)		214,929	0	214,929	6,792.00	31.64	35.00
36.00	Cafeteria	11.00	0	352,305	352,305	25,896.00	13.60	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,018,953	0	1,018,953	28,954.00	35.19	38.00
39.00	Central Services and Supply	14.00	155,958	-155,958	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	855,224	0	855,224	23,487.00	36.41	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150097

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

Worksheet S-3
Part II
Date/Time Prepared:
5/20/2015 1:28 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	
41.00	Medical Records & Medical Records Library	16.00 667,187	0	667,187	31,800.00	20.98	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150097

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

Worksheet S-3
Part III
Date/Time Prepared:
5/20/2015 1:28 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries 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)	33,876,502	0	33,876,502	1,180,255.00	28.70	1.00
2.00	Excluded area salaries (see instructions)	3,025,762	204,267	3,230,029	73,375.00	44.02	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30,850,740	-204,267	30,646,473	1,106,880.00	27.69	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,136,535	0	1,136,535	9,973.00	113.96	4.00
5.00	Subtotal wage-related costs (see inst.)	9,090,924	0	9,090,924	0.00	29.66	5.00
6.00	Total (sum of lines 3 thru 5)	41,078,199	-204,267	40,873,932	1,116,853.00	36.60	6.00
7.00	Total overhead cost (see instructions)	12,868,825	-360,225	12,508,600	444,028.00	28.17	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/20/2015 1:28 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)		1,744,554	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)		5,442,511	8.00
9.00	Prescription Drug Plan		26,233	9.00
10.00	Dental, Hearing and Vision Plan		39,022	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		53,998	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)		129,516	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		117,157	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,418,672	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		78,347	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		-9,905	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		10,040,105	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: 150097

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

Worksheet S-3
Part V
Date/Time Prepared:
5/20/2015 1:28 pm

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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150097 Component CCN: 157418		Period: From 01/01/2014 To 12/31/2014		Worksheet S-4 Date/Time Prepared: 5/20/2015 1:28 pm		
				Home Health Agency I		PPS		
							1.00	
0.00	County							0.00
		Title V	Title XVIII	Title XIX	Other	Total		
		1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours	0	0	0	0	0	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	325.00	16.00	75.00	0.00	2.00	
		Number of Employees (Full Time Equivalent)						
		Enter the number of hours in your normal work week			Staff	Contract	Total	
		0			1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	0.00					3.00	
4.00	Director(s) and Assistant Director(s)	0.00					4.00	
5.00	Other Administrative Personnel	0.00					5.00	
6.00	Direct Nursing Service	0.00					6.00	
7.00	Nursing Supervisor	0.00					7.00	
8.00	Physical Therapy Service	0.00					8.00	
9.00	Physical Therapy Supervisor	0.00					9.00	
10.00	Occupational Therapy Service	0.00					10.00	
11.00	Occupational Therapy Supervisor	0.00					11.00	
12.00	Speech Pathology Service	0.00					12.00	
13.00	Speech Pathology Supervisor	0.00					13.00	
14.00	Medical Social Service	0.00					14.00	
15.00	Medical Social Service Supervisor	0.00					15.00	
16.00	Home Health Aide	0.00					16.00	
17.00	Home Health Aide Supervisor	0.00					17.00	
18.00	Other (specify)	0.00					18.00	
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				2		19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	26900					20.00	
20.01		50032					20.01	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers	3.00	4.00	5.00		
		1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	3,688	369	78	34	4,169	21.00	
22.00	Skilled Nursing Visit Charges	771,452	80,364	12,654	6,882	871,352	22.00	
23.00	Physical Therapy Visits	1,949	94	24	32	2,099	23.00	
24.00	Physical Therapy Visit Charges	384,865	18,779	3,587	5,275	412,506	24.00	
25.00	Occupational Therapy Visits	417	19	0	0	436	25.00	
26.00	Occupational Therapy Visit Charges	91,207	4,237	0	0	95,444	26.00	
27.00	Speech Pathology Visits	44	19	0	0	63	27.00	
28.00	Speech Pathology Visit Charges	9,534	4,086	0	0	13,620	28.00	
29.00	Medical Social Service Visits	31	19	0	0	50	29.00	
30.00	Medical Social Service Visit Charges	9,548	5,852	0	0	15,400	30.00	
31.00	Home Health Aide Visits	1,149	169	2	9	1,329	31.00	
32.00	Home Health Aide Visit Charges	127,008	18,704	224	1,008	146,944	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,278	689	104	75	8,146	33.00	
34.00	Other Charges	0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,393,614	132,022	16,465	13,165	1,555,266	35.00	
36.00	Total Number of Episodes (standard/non outlier)	355		28	5	388	36.00	
37.00	Total Number of Outlier Episodes		15		1	16	37.00	
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/20/2015 1:28 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.292633	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,240,732	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?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		-33,821	5.00	
6.00	Medicaid charges		28,869,942	6.00	
7.00	Medicaid cost (line 1 times line 6)		8,448,298	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)		1,241,387	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)		1,241,387	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	6,323,511	0	6,323,511	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,850,468	0	1,850,468	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)	1,850,468	0	1,850,468	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)		9,516,555	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		147,674	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		9,368,881	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,741,644	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,592,112	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,833,499	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150097

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

Worksheet A
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		4,844,863	4,844,863	0	4,844,863	1.00
3.00	00300		0	0	0	0	3.00
4.00	00400		7,739,292	8,267,857	0	8,267,857	4.00
5.01	01160	0	0	0	15,000	15,000	5.01
5.02	00550	1,184,544	2,407,951	3,592,495	0	3,592,495	5.02
5.03	00590	186,366	96,602	282,968	0	282,968	5.03
5.04	00570	883,965	119,075	1,003,040	-15,000	988,040	5.04
5.05	00580	587,942	1,009,377	1,597,319	0	1,597,319	5.05
5.06	00592	3,876,765	4,575,204	8,451,969	-404,873	8,047,096	5.06
7.00	00700	754,273	1,164,640	1,918,913	0	1,918,913	7.00
8.00	00800	24,216	169,975	194,191	0	194,191	8.00
9.00	00900	715,946	424,758	1,140,704	0	1,140,704	9.00
10.00	01000	515,750	853,753	1,369,503	-935,557	433,946	10.00
11.00	01100	0	0	0	935,557	935,557	11.00
13.00	01300	1,018,953	209,145	1,228,098	0	1,228,098	13.00
14.00	01400	155,958	215,776	371,734	-367,307	4,427	14.00
15.00	01500	855,224	5,165,377	6,020,601	0	6,020,601	15.00
16.00	01600	667,187	291,493	958,680	0	958,680	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,732,520	1,180,875	5,913,395	23,685	5,937,080	30.00
31.00	03100	978,806	312,314	1,291,120	0	1,291,120	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,405,045	1,753,559	4,158,604	137,422	4,296,026	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	2,122,430	362,354	2,484,784	0	2,484,784	53.00
54.00	05400	1,865,137	2,375,616	4,240,753	0	4,240,753	54.00
56.00	05600	0	0	0	0	0	56.00
56.01	05601	1,055,586	844,885	1,900,471	0	1,900,471	56.01
57.00	05700	357,348	901,680	1,259,028	0	1,259,028	57.00
58.00	05800	285,129	626,262	911,391	0	911,391	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,755,384	2,925,757	4,681,141	0	4,681,141	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	737,820	181,433	919,253	0	919,253	65.00
65.01	06501	377,527	202,431	579,958	0	579,958	65.01
66.00	06600	1,320,761	606,138	1,926,899	0	1,926,899	66.00
69.00	06900	391,335	185,704	577,039	0	577,039	69.00
71.00	07100	84,834	2,825,153	2,909,987	-1,291,545	1,618,442	71.00
72.00	07200	0	0	0	1,291,545	1,291,545	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	163,123	262,175	425,298	0	425,298	90.00
91.00	09100	1,903,115	1,785,051	3,688,166	206,200	3,894,366	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	587,409	587,409	0	587,409	95.00
97.00	09700	0	0	0	0	0	97.00
100.00	10000	0	0	0	0	0	100.00
101.00	10100	683,760	477,273	1,161,033	0	1,161,033	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		33,175,314	47,683,350	80,858,664	-404,873	80,453,791	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	0	0	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
190.05	19005	0	0	0	404,873	404,873	190.05
190.06	19006	0	0	0	0	0	190.06
190.07	19007	144,605	473,987	618,592	0	618,592	190.07
190.08	19008	0	0	0	0	0	190.08
190.09	19009	11,649	87,052	98,701	0	98,701	190.09
190.10	19010	0	0	0	0	0	190.10
190.11	19011	0	0	0	0	0	190.11
190.12	19012	0	0	0	0	0	190.12
190.13	19013	0	0	0	0	0	190.13

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150097

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

Worksheet A
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
190.14	19014	SPORTSWORKS	0	0	0	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	0	0	0	190.15
190.16	19016	RENOVO	0	1	1	0	1	190.16
190.17	19017	I MA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	1,161,112	1,161,112	0	1,161,112	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	1,614,023	141,683	1,755,706	0	1,755,706	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	571,725	191,968	763,693	0	763,693	194.00
200.00		TOTAL (SUM OF LINES 118-199)	35,517,316	49,739,153	85,256,469	0	85,256,469	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150097

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

Worksheet A
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-476,314	4,368,549	1.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-6,730	8,261,127	4.00
5.01	01160	COMMUNICATIONS	-2,840	12,160	5.01
5.02	00550	DATA PROCESSING	-269,376	3,323,119	5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES	0	282,968	5.03
5.04	00570	ADMINISTRATIVE	-6,504	981,536	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	-55,092	1,542,227	5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL	-1,066,887	6,980,209	5.06
7.00	00700	OPERATION OF PLANT	0	1,918,913	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	194,191	8.00
9.00	00900	HOUSEKEEPING	0	1,140,704	9.00
10.00	01000	DIETARY	-214,273	219,673	10.00
11.00	01100	CAFETERIA	-526,773	408,784	11.00
13.00	01300	NURSING ADMINISTRATION	-97,870	1,130,228	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,427	14.00
15.00	01500	PHARMACY	-199,085	5,821,516	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-22,859	935,821	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-345,653	5,591,427	30.00
31.00	03100	INTENSIVE CARE UNIT	-32,303	1,258,817	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-621,784	3,674,242	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,844,407	640,377	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-613,089	3,627,664	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	-215,432	1,685,039	56.01
57.00	05700	CT SCAN	-182,277	1,076,751	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-89,765	821,626	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-355,170	4,325,971	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-33,535	885,718	65.00
65.01	06501	SLEEP LAB	-33,505	546,453	65.01
66.00	06600	PHYSICAL THERAPY	-96,063	1,830,836	66.00
69.00	06900	ELECTROCARDIOLOGY	-53,080	523,959	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-132,819	1,485,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,291,545	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-155,081	270,217	90.00
91.00	09100	EMERGENCY	-1,058,221	2,836,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,857,513	2,444,922	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	-1,083	1,159,950	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,950,357	73,503,434	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	190.04
190.05	19005	MARKETING	0	404,873	190.05
190.06	19006	MH LIGHTBOUND	0	0	190.06
190.07	19007	I-74 CAMPUS	0	618,592	190.07
190.08	19008	SOUTHEAST OB	0	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	0	98,701	190.09
190.10	19010	MS&M	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	190.12
190.13	19013	SSA	0	0	190.13
190.14	19014	SPORTSWORKS	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	190.15

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150097

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

Worksheet A
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
190.16	19016	RENOVO	0	1	190.16
190.17	19017	I MA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	-28,782	1,132,330	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	-17,996	1,737,710	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	-5,476	758,217	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-7,002,611	78,253,858	200.00

RECLASSIFICATIONS

Provider CCN: 150097

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

Worksheet A-6

Date/Time Prepared:
5/20/2015 1:28 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	352,305	583,252	1.00
	O		352,305	583,252	
B - COMMUNICATIONS					
1.00	COMMUNICATIONS	5.01	15,000	0	1.00
	O		15,000	0	
C - CS&R OTHER					
1.00	ADULTS & PEDIATRICS	30.00	10,057	13,628	1.00
2.00	OPERATING ROOM	50.00	58,349	79,073	2.00
3.00	EMERGENCY	91.00	87,552	118,648	3.00
	O		155,958	211,349	
D - MARKETING					
1.00	MARKETING	190.05	204,267	200,606	1.00
	O		204,267	200,606	
E - IMPLANTABLE DEVICES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	36,293	1,255,252	1.00
	O		36,293	1,255,252	
500.00	Grand Total: Increases		763,823	2,250,459	500.00

RECLASSIFICATIONS

Provider CCN: 150097

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

Worksheet A-6

Date/Time Prepared:
5/20/2015 1:28 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	352,305	583,252	0		1.00
	O		352,305	583,252			
B - COMMUNICATIONS							
1.00	ADMINISTRATIVE	5.04	15,000	0	0		1.00
	O		15,000	0			
C - CS&R OTHER							
1.00	CENTRAL SERVICES & SUPPLY	14.00	155,958	211,349	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	O		155,958	211,349			
D - MARKETING							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	204,267	200,606	0		1.00
	O		204,267	200,606			
E - IMPLANTABLE DEVICES RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	36,293	1,255,252	0		1.00
	O		36,293	1,255,252			
500.00	Grand Total: Decreases		763,823	2,250,459			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150097

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

Worksheet A-7
Part I
Date/Time Prepared:
5/20/2015 1:28 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	4,737,322	0	0	3,000,000	1.00
2.00	Land Improvements	5,999,316	13,811	0	73,516	2.00
3.00	Buildings and Fixtures	31,527,163	0	0	750,000	3.00
4.00	Building Improvements	3,632,737	5,744,913	0	893,327	4.00
5.00	Fixed Equipment	2,426,323	500,374	0	1,425,477	5.00
6.00	Movable Equipment	33,021,747	1,362,919	0	901,348	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	81,344,608	7,622,017	0	7,043,668	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	81,344,608	7,622,017	0	7,043,668	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,737,322	0			1.00
2.00	Land Improvements	5,939,611	0			2.00
3.00	Buildings and Fixtures	30,777,163	0			3.00
4.00	Building Improvements	8,484,323	0			4.00
5.00	Fixed Equipment	1,501,220	0			5.00
6.00	Movable Equipment	33,483,318	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	81,922,957	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	81,922,957	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150097

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

Worksheet A-7
Part II
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	3,104,631	0	649,114	0	0	1.00
3.00	Total (sum of lines 1-2)	3,104,631	0	649,114	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,091,118	4,844,863				1.00
3.00	Total (sum of lines 1-2)	1,091,118	4,844,863				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150097

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

Worksheet A-7
Part III
Date/Time Prepared:
5/20/2015 1:28 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	CAP REL COSTS-BLDG & FIXT	81,922,957	0	81,922,957	1.000000	0	1.00	
3.00	Total (sum of lines 1-2)	81,922,957	0	81,922,957	1.000000	0	3.00	
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,099,412	0	1.00	
3.00	Total (sum of lines 1-2)	0	0	0	3,099,412	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	CAP REL COSTS-BLDG & FIXT	178,019	0	0	1,091,118	4,368,549	1.00	
3.00	Total (sum of lines 1-2)	178,019	0	0	1,091,118	4,368,549	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 150097

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

Worksheet A-8

Date/Time Prepared:
5/20/2015 1:28 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	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-471,095	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00		2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-2,840	COMMUNICATIONS	5.01	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,244,449			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,868,642			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	A	-273,415	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 FOOD AND NUTRITION	B	-44,642	DIETARY	10.00	0	33.00
34.00 DIABETIC ED	B	-91,579	NURSING ADMINISTRATION	13.00	0	34.00

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	
35.00 CAFETERIA - EMP	A	-253,358	CAFETERIA		11.00	0 35.00
36.00 MH OTHER REVENUES RENTAL INCOME	B	-2,451	CAP REL COSTS-BLDG & FIXT		1.00	9 36.00
37.00 MH INFO. SYSTEMS CONTRACT LABOR	A	-263,376	DATA PROCESSING		5.02	0 37.00
38.00 MH REGISTRATION CONTRACT LABOR	A	-6,504	ADMINING		5.04	0 38.00
39.00 MH PT FINANCE SVCS CONTRACT LABOR	A	-55,092	CASHIERING/ACCOUNTS RECEIVABLE		5.05	0 39.00
40.00 MH ACCOUNTING CONTRACT LABOR	A	-126,756	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 40.00
41.00 MH ADMINISTRATION CONTRACT LABOR	A	-166,764	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 41.00
42.00 MH OTHER REVENUES PURCHASE DISCOUNTS	B	-4,699	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 42.00
43.00 MH OTHER REVENUES REAPPOINTMENT FEES	B	-4,750	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 43.00
44.00 MH EDUCATION CLASS REVENUE	B	-13,434	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 44.00
45.00 MH MDSOLUTIONS-ADM RENTAL INCOME	B	-31,420	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.00
45.01 MH OTHER REVENUES MISCELLANEOUS INCO	B	-13,220	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.01
45.02 MH ACCOUNTING VENDOR REBATES	B	-33,766	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.02
45.03 MH CL NUTR/DIABED CLASS REVENUE	B	-2,214	NURSING ADMINISTRATION		13.00	0 45.03
45.04 MH CL NUTR/DIABED OTHER CAFETERIA R	B	-3,024	NURSING ADMINISTRATION		13.00	0 45.04
45.05 MH PHARMACY VENDOR REBATES	B	-10,152	PHARMACY		15.00	0 45.05
45.06 MH OTHER REVENUES XEROX AND COPYING	B	-22,859	MEDICAL RECORDS & LIBRARY		16.00	0 45.06
45.07 MH COMM. OUTREACH CONTRACT LABOR	A	-34,410	ADULTS & PEDIATRICS		30.00	0 45.07
45.08 MH OTHER REVENUES BABY PHOTO INCOME	B	-507	ADULTS & PEDIATRICS		30.00	0 45.08
45.09 MH ICU OTHER INCOME	B	-3,550	INTENSIVE CARE UNIT		31.00	0 45.09
45.10 MH REHAB SVCS-SWK CONTRACT LABOR	A	-63,648	PHYSICAL THERAPY		66.00	0 45.10
45.11 MH CAR MGT & REHAB CONTRACT LABOR	A	-20,244	ELECTROCARDIOLOGY		69.00	0 45.11
45.12 MH CENTRAL SUPPLY VENDOR REBATES	B	-21,926	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0 45.12
45.13 INVEST. INC - CAP - B&F	B	-175	OPERATING ROOM		50.00	0 45.13
45.14 INVEST. INC -CAP - B&F	B	-726	CT SCAN		57.00	0 45.14
45.15 MEALS ON WHEELS	A	-169,631	DIETARY		10.00	0 45.15
45.16 DEPR - OLD B&F	A	-2,768	CAP REL COSTS-BLDG & FIXT		1.00	9 45.16
45.17 IHHA/AHA DUES	A	-5,214	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.17
45.18 PROMOTIONAL GIFTS	A	-84	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.18
45.19 PROMOTIONAL GIFTS	A	-6,000	DATA PROCESSING		5.02	0 45.19
45.20 PROMOTIONAL GIFTS	A	-694	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.20
45.21 PROMOTIONAL GIFTS	A	-134	NURSING ADMINISTRATION		13.00	0 45.21
45.22 PROMOTIONAL GIFTS	A	-1,502	ADULTS & PEDIATRICS		30.00	0 45.22
45.23 PROMOTIONAL GIFTS	A	-506	RADIOLOGY-DIAGNOSTIC		54.00	0 45.23
45.24 PROMOTIONAL GIFTS	A	-882	ONCOLOGY		56.01	0 45.24
45.25 PROMOTIONAL GIFTS	A	-502	RESPIRATORY THERAPY		65.00	0 45.25
45.26 PROMOTIONAL GIFTS	A	-416	SLEEP LAB		65.01	0 45.26
45.27 PROMOTIONAL GIFTS	A	-1,213	ELECTROCARDIOLOGY		69.00	0 45.27
45.28 PROMOTIONAL GIFTS	A	-48	EMERGENCY		91.00	0 45.28
45.29 ADVERTISING EXPENSE	A	-3,217	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.29
45.30 ADVERTISING EXPENSE	A	-2,964	PHYSICAL THERAPY		66.00	0 45.30
45.31 COMMUNITY OUTREACH	A	-656,521	OTHER ADMINISTRATIVE AND GENERAL		5.06	0 45.31
45.32 HAF EXPENSE	A	-919	NURSING ADMINISTRATION		13.00	0 45.32
45.33 HAF EXPENSE	A	-188,933	PHARMACY		15.00	0 45.33
45.34 HAF EXPENSE	A	-309,234	ADULTS & PEDIATRICS		30.00	0 45.34
45.35 HAF EXPENSE	A	-28,753	INTENSIVE CARE UNIT		31.00	0 45.35
45.36 HAF EXPENSE	A	-261,609	OPERATING ROOM		50.00	0 45.36

Provider CCN: 150097

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

Worksheet A-8

Date/Time Prepared:
 5/20/2015 1:28 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	
45.37 HAF EXPENSE	A	-64,021	ANESTHESIOLOGY	53.00	0 45.37
45.38 HAF EXPENSE	A	-221,580	RADIOLOGY-DIAGNOSTIC	54.00	0 45.38
45.39 HAF EXPENSE	A	-67,074	ONCOLOGY	56.01	0 45.39
45.40 HAF EXPENSE	A	-181,045	CT SCAN	57.00	0 45.40
45.41 HAF EXPENSE	A	-89,765	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0 45.41
45.42 HAF EXPENSE	A	-355,170	LABORATORY	60.00	0 45.42
45.43 HAF EXPENSE	A	-33,033	RESPIRATORY THERAPY	65.00	0 45.43
45.44 HAF EXPENSE	A	-33,089	SLEEP LAB	65.01	0 45.44
45.45 HAF EXPENSE	A	-26,070	PHYSICAL THERAPY	66.00	0 45.45
45.46 HAF EXPENSE	A	-31,623	ELECTROCARDIOLOGY	69.00	0 45.46
45.47 HAF EXPENSE	A	-110,893	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 45.47
45.48 HAF EXPENSE	A	-4,448	CLINIC	90.00	0 45.48
45.49 HAF EXPENSE	A	-660,187	EMERGENCY	91.00	0 45.49
45.50 HAF EXPENSE	A	-11,129	AMBULANCE SERVICES	95.00	0 45.50
45.51 HAF EXPENSE	A	-1,083	HOME HEALTH AGENCY	101.00	0 45.51
45.52 HAF EXPENSE	A	-28,782	MHCD	190.19	0 45.52
45.53 HAF EXPENSE	A	-17,996	HOSPITALIST	192.01	0 45.53
45.54 HAF EXPENSE	A	-5,476	OTHER NONREIMBURSABLE COST CENTERS	194.00	0 45.54
45.55		0		0.00	0 45.55
45.56		0		0.00	0 45.56
45.57		0		0.00	0 45.57
45.58		0		0.00	0 45.58
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,002,611			50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 150097

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

Worksheet A-8-1

Date/Time Prepared:
5/20/2015 1:28 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	95.00	AMBULANCE SERVICES	1,868,642	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	0	1,868,642	0	5.00

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

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

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

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

6.00	G	SHELBY COUNTY A	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	AMBULANCE			100.00

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

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

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

Provider CCN: 150097

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

Worksheet A-8-1

Date/Time Prepared:
5/20/2015 1:28 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,868,642	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	1,868,642			5.00

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

Related Organization(s) and/or Home Office	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150097

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

Worksheet A-8-2

Date/Time Prepared:
5/20/2015 1:28 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	31,367	0	31,367	171,400	300	1.00
2.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	31,153	0	31,153	171,400	300	2.00
3.00	50.00	OPERATING ROOM	360,000	360,000	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	1,952,280	1,571,954	380,326	171,400	2,086	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	391,003	391,003	0	0	0	5.00
6.00	56.01	ONCOLOGY	154,645	140,062	14,583	171,400	87	6.00
7.00	57.00	CT SCAN	506	506	0	0	0	7.00
8.00	60.00	LABORATORY	54,095	0	54,095	219,500	726	8.00
9.00	66.00	PHYSICAL THERAPY	22,499	0	22,499	171,400	232	9.00
10.00	90.00	CLINIC	220,759	77,960	142,799	171,400	851	10.00
11.00	91.00	EMERGENCY	684,999	12,500	672,499	171,400	3,483	11.00
200.00			3,903,306	2,553,985	1,349,321		8,065	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	24,721	1,236	0	0	0	1.00
2.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	24,721	1,236	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	171,894	8,595	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	56.01	ONCOLOGY	7,169	358	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	76,614	3,831	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	19,118	956	0	0	0	9.00
10.00	90.00	CLINIC	70,126	3,506	0	0	0	10.00
11.00	91.00	EMERGENCY	287,013	14,351	0	0	0	11.00
200.00			681,376	34,069	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	24,721	6,646	6,646	1.00
2.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	24,721	6,432	6,432	2.00
3.00	50.00	OPERATING ROOM	0	0	0	360,000	3.00
4.00	53.00	ANESTHESIOLOGY	0	171,894	208,432	1,780,386	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	391,003	5.00
6.00	56.01	ONCOLOGY	0	7,169	7,414	147,476	6.00
7.00	57.00	CT SCAN	0	0	0	506	7.00
8.00	60.00	LABORATORY	0	76,614	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	0	19,118	3,381	3,381	9.00
10.00	90.00	CLINIC	0	70,126	72,673	150,633	10.00
11.00	91.00	EMERGENCY	0	287,013	385,486	397,986	11.00
200.00			0	681,376	690,464	3,244,449	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	
		BLDG & FIXT					
	0	1.00		4.00		5.01	5.02
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,368,549	4,368,549				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,261,127	18,193	8,279,320			4.00
5.01 01160	COMMUNICATIONS	12,160	9,804	3,549	25,513		5.01
5.02 00550	DATA PROCESSING	3,323,119	22,842	280,296	1,213	3,627,470	5.02
5.03 00590	PURCHASING, RECEIVING, AND STORES	282,968	24,560	44,099	388	19,643	5.03
5.04 00570	ADMITTING	981,536	54,511	205,621	1,067	183,338	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,542,227	0	139,124	0	91,669	5.05
5.06 00592	OTHER ADMINISTRATIVE AND GENERAL	6,980,209	357,555	869,016	1,746	288,102	5.06
7.00 00700	OPERATION OF PLANT	1,918,913	381,172	178,482	679	98,217	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	194,191	18,698	5,730	0	6,548	8.00
9.00 00900	HOUSEKEEPING	1,140,704	8,658	169,413	194	170,242	9.00
10.00 01000	DIETARY	219,673	82,945	38,676	437	117,860	10.00
11.00 01100	CAFETERIA	408,784	131,358	83,365	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,130,228	56,701	241,113	2,134	91,669	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,427	107,169	0	243	26,191	14.00
15.00 01500	PHARMACY	5,821,516	48,784	202,370	437	72,026	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	935,821	74,220	157,875	776	98,217	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	5,591,427	817,761	1,122,229	3,683	550,013	30.00
31.00 03100	INTENSIVE CARE UNIT	1,258,817	250,420	231,613	922	117,860	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	3,674,242	328,076	582,908	2,377	268,459	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	640,377	15,868	502,226	0	32,739	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,627,664	313,084	441,344	1,358	202,981	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01 05601	ONCOLOGY	1,685,039	559,865	249,781	2,425	111,312	56.01
57.00 05700	CT SCAN	1,076,751	13,476	84,559	0	26,191	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	821,626	0	67,470	0	19,643	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	4,325,971	67,549	415,373	1,067	255,363	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	885,718	28,165	174,589	146	72,026	65.00
65.01 06501	SLEEP LAB	546,453	0	89,333	194	39,287	65.01
66.00 06600	PHYSICAL THERAPY	1,830,836	21,225	312,529	1,164	130,956	66.00
69.00 06900	ELECTROCARDIOLOGY	523,959	95,108	92,601	0	58,930	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,485,623	0	11,486	0	19,643	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	1,291,545	0	8,588	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	270,217	168,350	38,599	776	32,739	90.00
91.00 09100	EMERGENCY	2,836,145	178,592	471,048	1,019	209,529	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	2,444,922	0	0	0	0	95.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00 10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	1,159,950	0	161,797	0	72,026	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	73,503,434	4,254,709	7,676,802	24,445	3,483,419	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,533	0	0	0	190.00
190.01 19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02 19002	SICK CHILD CARE	0	0	0	0	0	190.02
190.03 19003	PRIVATE DUTY	0	0	0	0	0	190.03
190.04 19004	ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05 19005	MARKETING	404,873	6,469	48,335	0	0	190.05
190.06 19006	MH LIGHTBOUND	0	0	0	0	0	190.06
190.07 19007	I-74 CAMPUS	618,592	0	34,218	49	32,739	190.07
190.08 19008	SOUTHEAST OB	0	0	0	0	0	190.08
190.09 19009	INTELLI PLEX DEVELOPMENT	98,701	0	2,756	0	0	190.09
190.10 19010	MS&M	0	0	0	0	0	190.10
190.11 19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		PURCHASING, RECEIVING, AND STORES	ADMINISTRATIVE	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL		
		5.03	5.04	5.05	5A.05	5.06		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	01160	COMMUNICATIONS					5.01	
5.02	00550	DATA PROCESSING					5.02	
5.03	00590	PURCHASING, RECEIVING, AND STORES	371,658				5.03	
5.04	00570	ADMINISTRATIVE	4,217	1,430,290			5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,754	0	1,775,774		5.05	
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL	6,731	0	0	8,503,359	5.06	
7.00	00700	OPERATION OF PLANT	220	0	0	2,577,683	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	225,167	8.00	
9.00	00900	HOUSEKEEPING	3,866	0	0	1,493,077	9.00	
10.00	01000	DIETARY	3,399	0	0	462,990	10.00	
11.00	01100	CAFETERIA	0	0	0	623,507	11.00	
13.00	01300	NURSING ADMINISTRATION	6,591	0	0	1,528,436	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	9,970	0	0	148,000	14.00	
15.00	01500	PHARMACY	3,972	0	0	6,149,105	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	2,662	0	0	1,269,571	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	51,283	85,565	106,232	8,328,193	30.00	
31.00	03100	INTENSIVE CARE UNIT	22,343	17,056	21,176	1,920,207	31.00	
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	86,941	168,680	209,422	5,321,105	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	20,259	5,428	6,739	1,223,636	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,806	128,195	159,159	4,883,591	54.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00	
56.01	05601	ONCOLOGY	12,087	71,417	88,667	2,780,593	56.01	
57.00	05700	CT SCAN	4,623	116,127	144,176	1,465,903	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,632	55,778	69,250	1,035,399	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	36,343	202,103	250,918	5,554,687	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	7,094	23,874	29,641	1,221,253	65.00	
65.01	06501	SLEEP LAB	3,366	23,647	29,358	731,638	65.01	
66.00	06600	PHYSICAL THERAPY	5,180	32,483	40,329	2,374,702	66.00	
69.00	06900	ELECTROCARDIOLOGY	8,125	27,519	34,166	840,408	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	484	54,164	67,246	1,638,646	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	40,497	50,279	1,390,909	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	124,745	154,876	279,621	73.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000	CLINIC	1,078	2,201	2,732	516,692	90.00	
91.00	09100	EMERGENCY	36,307	234,031	290,575	4,257,246	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	6,830	15,935	19,784	2,487,471	95.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00	
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00	
101.00	10100	HOME HEALTH AGENCY	6,441	845	1,049	1,402,108	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	364,604	1,430,290	1,775,774	72,634,903	7,818,347	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	12,533	1,528	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	459,677	56,040	190.05
190.06	19006	MH LIGHTBOUND	0	0	0	0	0	190.06
190.07	19007	I-74 CAMPUS	0	0	0	685,598	83,582	190.07
190.08	19008	SOUTHEAST OB	0	0	0	0	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	5	0	0	101,462	12,369	190.09
190.10	19010	MS&M	0	0	0	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0	190.12
190.13	19013	SSA	0	0	0	0	0	190.13
190.14	19014	SPORTSWORKS	0	0	0	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	0	0	0	190.15

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

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

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Cost Center Description			PURCHASING, RECEIVING, AND STORES	ADMINISTRATIVE	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.03	5.04	5.05	5A.05	5.06	
190.16	19016	RENOVO	0	0	0	1	0	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	1,141,224	139,128	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	58	0	0	2,165,525	264,001	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	6,991	0	0	1,052,935	128,364	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	371,658	1,430,290	1,775,774	78,253,858	8,503,359	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

Period:
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To 12/31/2014

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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	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	2,891,931				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,450	268,067			8.00
9.00	00900	HOUSEKEEPING	7,154	0	1,682,254		9.00
10.00	01000	DIETARY	68,537	0	40,182	628,153	10.00
11.00	01100	CAFETERIA	108,540	0	63,636	0	871,695
13.00	01300	NURSING ADMINISTRATION	46,851	0	27,468	0	32,255
14.00	01400	CENTRAL SERVICES & SUPPLY	88,552	0	51,917	0	0
15.00	01500	PHARMACY	40,309	0	23,633	0	25,947
16.00	01600	MEDICAL RECORDS & LIBRARY	61,327	0	35,955	0	35,143
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	675,706	105,805	396,160	570,177	191,284
31.00	03100	INTENSIVE CARE UNIT	206,918	15,580	121,314	57,976	41,310
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	271,085	37,461	158,934	0	89,676
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	13,112	0	7,687	0	17,385
54.00	05400	RADIOLOGY-DIAGNOSTIC	258,697	31,191	151,671	0	65,144
56.00	05600	RADIOISOTOPE	0	0	0	0	0
56.01	05601	ONCOLOGY	462,609	0	271,222	0	38,126
57.00	05700	CT SCAN	11,135	0	6,528	0	13,733
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	10,019
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	55,815	10	32,724	0	89,948
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	23,272	0	13,644	0	25,275
65.01	06501	SLEEP LAB	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	17,538	68	10,282	0	46,030
69.00	06900	ELECTROCARDIOLOGY	78,586	0	46,074	0	19,725
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,860
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,801
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	139,106	950	81,556	0	11,172
91.00	09100	EMERGENCY	147,568	76,858	86,518	0	77,442
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,797,867	267,923	1,627,105	628,153	836,275
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,356	0	6,071	0	0
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0
190.02	19002	SICK CHILD CARE	0	0	0	0	0
190.03	19003	PRIVATE DUTY	0	0	0	0	0
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0
190.05	19005	MARKETING	5,345	0	3,134	0	6,698
190.06	19006	MHLIGHTBOUND	0	0	0	0	0
190.07	19007	I-74 CAMPUS	0	0	0	0	11,403
190.08	19008	SOUTHEAST OB	0	0	0	0	0
190.09	19009	INTELLI PLEX DEVELOPMENT	0	0	0	0	647
190.10	19010	MS&M	0	0	0	0	0
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0
190.13	19013	SSA	0	0	0	0	0
190.14	19014	SPORTSWORKS	0	0	0	0	0
190.15	19015	SHELBY PEDS	0	0	0	0	0
190.16	19016	RENOVO	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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To 12/31/2014

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
190.17	19017	I MA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	7,349	0	4,309	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	0	0	0	16,672	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	71,014	144	41,635	0	0	194.00
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)	2,891,931	268,067	1,682,254	628,153	871,695	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

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

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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00590						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00592						5.06
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	1,821,343					13.00
14.00	01400	0	306,512				14.00
15.00	01500	0	0	6,988,638			15.00
16.00	01600	0	0	0	1,556,771		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	578,949	0	0	108,852	11,970,431	30.00
31.00	03100	125,029	0	0	18,367	2,740,795	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	271,418	0	0	181,642	6,980,022	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	52,619	0	0	5,845	1,469,459	53.00
54.00	05400	0	0	0	138,047	6,123,704	54.00
56.00	05600	0	0	0	0	0	56.00
56.01	05601	115,393	0	0	76,906	4,083,834	56.01
57.00	05700	0	0	0	125,051	1,801,060	57.00
58.00	05800	0	0	0	60,064	1,231,709	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	217,633	6,627,994	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	76,500	0	0	25,709	1,534,537	65.00
65.01	06501	43,775	0	0	25,464	890,072	65.01
66.00	06600	0	0	0	34,979	2,773,101	66.00
69.00	06900	59,701	0	0	29,634	1,176,583	69.00
71.00	07100	0	174,712	0	58,326	2,075,313	71.00
72.00	07200	0	131,800	0	43,609	1,738,686	72.00
73.00	07300	0	0	6,988,638	134,331	7,436,679	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	33,814	0	0	2,370	848,650	90.00
91.00	09100	234,390	0	0	251,873	5,650,900	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	17,159	2,807,880	95.00
97.00	09700	0	0	0	0	0	97.00
100.00	10000	0	0	0	0	0	100.00
101.00	10100	76,021	0	0	910	1,649,971	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,667,609	306,512	6,988,638	1,556,771	71,611,380	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	30,488	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	0	0	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
190.05	19005	0	0	0	0	530,894	190.05
190.06	19006	0	0	0	0	0	190.06
190.07	19007	34,513	0	0	0	815,096	190.07
190.08	19008	0	0	0	0	0	190.08
190.09	19009	1,959	0	0	0	116,437	190.09
190.10	19010	0	0	0	0	0	190.10
190.11	19011	0	0	0	0	0	190.11
190.12	19012	0	0	0	0	0	190.12
190.13	19013	0	0	0	0	0	190.13
190.14	19014	0	0	0	0	0	190.14
190.15	19015	0	0	0	0	0	190.15

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
190.16	19016	RENOVO	0	0	0	0	0	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	1,292,010	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	50,459	0	0	0	2,496,657	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	66,803	0	0	0	1,360,895	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,821,343	306,512	6,988,638	1,556,771	78,253,858	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	01160	COMMUNICATIONS		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES		5.03
5.04	00570	ADMINISTRATIVE		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL		5.06
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	11,970,431
31.00	03100	INTENSIVE CARE UNIT	0	2,740,795
41.00	04100	SUBPROVIDER - IRF	0	0
42.00	04200	SUBPROVIDER	0	0
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,980,022
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	1,469,459
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,123,704
56.00	05600	RADIOISOTOPE	0	0
56.01	05601	ONCOLOGY	0	4,083,834
57.00	05700	CT SCAN	0	1,801,060
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,231,709
59.00	05900	CARDIAC CATHETERIZATION	0	0
60.00	06000	LABORATORY	0	6,627,994
60.01	06001	BLOOD LABORATORY	0	0
65.00	06500	RESPIRATORY THERAPY	0	1,534,537
65.01	06501	SLEEP LAB	0	890,072
66.00	06600	PHYSICAL THERAPY	0	2,773,101
69.00	06900	ELECTROCARDIOLOGY	0	1,176,583
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,075,313
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,738,686
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,436,679
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0
90.00	09000	CLINIC	0	848,650
91.00	09100	EMERGENCY	0	5,650,900
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,807,880
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0
101.00	10100	HOME HEALTH AGENCY	0	1,649,971
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	71,611,380
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,488
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0
190.02	19002	SICK CHILD CARE	0	0
190.03	19003	PRIVATE DUTY	0	0
190.04	19004	ST. VINCENT'S STRESS	0	0
190.05	19005	MARKETING	0	530,894
190.06	19006	MHLIGHTBOUND	0	0
190.07	19007	I-74 CAMPUS	0	815,096
190.08	19008	SOUTHEAST OB	0	0
190.09	19009	INTELLI PLEX DEVELOPMENT	0	116,437
190.10	19010	MS&M	0	0
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0
190.12	19012	BARTLEY ORTHOPEDICS	0	0
190.13	19013	SSA	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150097

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

Worksheet B
Part I
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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.14	19014	SPORTSWORKS	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	190.15
190.16	19016	RENOVO	0	1	190.16
190.17	19017	I MA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	0	1,292,010	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	0	2,496,657	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	1,360,895	194.00
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	78,253,858	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

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

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT					
	0	1.00		2A	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	18,193	18,193	18,193		4.00
5.01 01160	COMMUNICATIONS	0	9,804	9,804	8	9,812	5.01
5.02 00550	DATA PROCESSING	0	22,842	22,842	616	466	5.02
5.03 00590	PURCHASING, RECEIVING, AND STORES	0	24,560	24,560	97	149	5.03
5.04 00570	ADMITTING	0	54,511	54,511	452	410	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	306	0	5.05
5.06 00592	OTHER ADMINISTRATIVE AND GENERAL	0	357,555	357,555	1,910	672	5.06
7.00 00700	OPERATION OF PLANT	0	381,172	381,172	392	261	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	18,698	18,698	13	0	8.00
9.00 00900	HOUSEKEEPING	0	8,658	8,658	372	75	9.00
10.00 01000	DIETARY	0	82,945	82,945	85	168	10.00
11.00 01100	CAFETERIA	0	131,358	131,358	183	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	56,701	56,701	530	821	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	107,169	107,169	0	93	14.00
15.00 01500	PHARMACY	0	48,784	48,784	445	168	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	74,220	74,220	347	298	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	817,761	817,761	2,464	1,418	30.00
31.00 03100	INTENSIVE CARE UNIT	0	250,420	250,420	509	354	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	328,076	328,076	1,281	914	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	15,868	15,868	1,104	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	313,084	313,084	970	522	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01 05601	ONCOLOGY	0	559,865	559,865	549	933	56.01
57.00 05700	CT SCAN	0	13,476	13,476	186	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	148	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	67,549	67,549	913	410	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	28,165	28,165	384	56	65.00
65.01 06501	SLEEP LAB	0	0	0	196	75	65.01
66.00 06600	PHYSICAL THERAPY	0	21,225	21,225	687	448	66.00
69.00 06900	ELECTROCARDIOLOGY	0	95,108	95,108	203	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	19	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	168,350	168,350	85	298	90.00
91.00 09100	EMERGENCY	0	178,592	178,592	1,035	392	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	356	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,254,709	4,254,709	16,870	9,401	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,533	12,533	0	0	190.00
190.01 19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02 19002	SICK CHILD CARE	0	0	0	0	0	190.02
190.03 19003	PRIVATE DUTY	0	0	0	0	0	190.03
190.04 19004	ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05 19005	MARKETING	0	6,469	6,469	106	0	190.05
190.06 19006	MH LIGHTBOUND	0	0	0	0	0	190.06
190.07 19007	I-74 CAMPUS	0	0	0	75	19	190.07
190.08 19008	SOUTHEAST OB	0	0	0	0	0	190.08
190.09 19009	INTELLI PLEX DEVELOPMENT	0	0	0	6	0	190.09
190.10 19010	MS&M	0	0	0	0	0	190.10
190.11 19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11
190.12 19012	BARTLEY ORTHOPEDICS	0	0	0	0	0	190.12

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
			BLDG & FIXT				
	0	1.00		2A	4.00	5.01	
190.13 19013 SSA	0	0	0	0	0	0	0 190.13
190.14 19014 SPORTSWORKS	0	0	0	0	0	0	0 190.14
190.15 19015 SHELBY PEDS	0	0	0	0	0	0	0 190.15
190.16 19016 RENOVO	0	0	0	0	0	0	0 190.16
190.17 19017 IMA	0	0	0	0	0	0	0 190.17
190.18 19018 MD SOLUTIONS	0	0	0	0	0	0	0 190.18
190.19 19019 MHCD	0	8,894	0	8,894	0	0	0 190.19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	0 192.00
192.01 19201 HOSPITALIST	0	0	0	0	839	0	0 192.01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	85,944	0	85,944	297	392	0 194.00
200.00 Cross Foot Adjustments				0			200.00
201.00 Negative Cost Centers				0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	0	4,368,549		4,368,549	18,193	9,812	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/20/2015 1:28 pm		
Cost Center Description		DATA PROCESSING	PURCHASING, RECEIVING, AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL		
		5.02	5.03	5.04	5.05	5.06		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING	23,924					5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES	130	24,936				5.03
5.04	00570	ADMINITTING	1,209	283	56,865			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	605	185	0	1,096		5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL	1,900	452	0	0	362,489	5.06
7.00	00700	OPERATION OF PLANT	648	15	0	0	13,396	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43	0	0	0	1,170	8.00
9.00	00900	HOUSEKEEPING	1,123	259	0	0	7,760	9.00
10.00	01000	DIETARY	777	228	0	0	2,406	10.00
11.00	01100	CAFETERIA	0	0	0	0	3,240	11.00
13.00	01300	NURSING ADMINISTRATION	605	442	0	0	7,943	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	173	669	0	0	769	14.00
15.00	01500	PHARMACY	475	267	0	0	31,957	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	648	179	0	0	6,598	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,624	3,441	3,403	72	43,279	30.00
31.00	03100	INTENSIVE CARE UNIT	777	1,499	678	14	9,979	31.00
41.00	04100	SUBPROVIDER - I R F	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,771	5,834	6,710	143	27,654	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	216	1,359	216	5	6,359	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,339	658	5,099	108	25,380	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	ONCOLOGY	734	811	2,841	60	14,451	56.01
57.00	05700	CT SCAN	173	310	4,619	98	7,618	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	130	109	2,219	47	5,381	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,684	2,438	8,039	171	28,868	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	475	476	950	20	6,347	65.00
65.01	06501	SLEEP LAB	259	226	941	20	3,802	65.01
66.00	06600	PHYSICAL THERAPY	864	348	1,292	27	12,341	66.00
69.00	06900	ELECTROCARDIOLOGY	389	545	1,095	23	4,368	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130	32	2,154	46	8,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	1,611	34	7,229	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,962	106	1,453	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	216	72	88	2	2,685	90.00
91.00	09100	EMERGENCY	1,382	2,436	9,280	86	22,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	458	634	13	12,927	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	475	432	34	1	7,287	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,974	24,463	56,865	1,096	333,288	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	65	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	0	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	0	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05	19005	MARKETING	0	0	0	0	2,389	190.05
190.06	19006	MH LIGHTBOUND	0	0	0	0	0	190.06
190.07	19007	I-74 CAMPUS	216	0	0	0	3,563	190.07
190.08	19008	SOUTHEAST OB	0	0	0	0	0	190.08
190.09	19009	INTELLEX DEVELOPMENT	0	0	0	0	527	190.09
190.10	19010	MS&M	0	0	0	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0	190.12
190.13	19013	SSA	0	0	0	0	0	190.13
190.14	19014	SPORTSWORKS	0	0	0	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	0	0	0	190.15

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/20/2015 1:28 pm	
Cost Center Description			DATA PROCESSING	PURCHASING, RECEIVING, AND STORES	ADMINISTRATIVE	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5.05	5.06	
190.16	19016	RENOVO	0	0	0	0	0	190.16
190.17	19017	IMA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	5,931	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	302	4	0	0	11,254	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	432	469	0	0	5,472	194.00
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)	23,924	24,936	56,865	1,096	362,489	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/20/2015 1:28 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	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT	395,884				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,115	22,039			8.00
9.00	00900	HOUSEKEEPING	979	0	19,226		9.00
10.00	01000	DIETARY	9,382	0	459	96,450	10.00
11.00	01100	CAFETERIA	14,858	0	727	0	11.00
13.00	01300	NURSING ADMINISTRATION	6,414	0	314	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,122	0	593	0	14.00
15.00	01500	PHARMACY	5,518	0	270	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,395	0	411	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	92,498	8,698	4,528	87,548	30.00
31.00	03100	INTENSIVE CARE UNIT	28,326	1,281	1,386	8,902	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,109	3,080	1,816	0	15,469
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	1,795	0	88	0	2,999
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,414	2,564	1,733	0	11,237
56.00	05600	RADIOISOTOPE	0	0	0	0	0
56.01	05601	ONCOLOGY	63,328	0	3,100	0	6,577
57.00	05700	CT SCAN	1,524	0	75	0	2,369
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,728
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	7,641	1	374	0	15,516
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,186	0	156	0	4,360
65.01	06501	SLEEP LAB	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	2,401	6	118	0	7,940
69.00	06900	ELECTROCARDIOLOGY	10,758	0	527	0	3,403
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	666
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	483
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	19,043	78	932	0	1,927
91.00	09100	EMERGENCY	20,201	6,319	989	0	13,359
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	383,007	22,027	18,596	96,450	144,256
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,418	0	69	0	0
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0
190.02	19002	SICK CHILD CARE	0	0	0	0	0
190.03	19003	PRIVATE DUTY	0	0	0	0	0
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0
190.05	19005	MARKETING	732	0	36	0	1,155
190.06	19006	MHLIGHTBOUND	0	0	0	0	0
190.07	19007	I-74 CAMPUS	0	0	0	0	1,967
190.08	19008	SOUTHEAST OB	0	0	0	0	0
190.09	19009	INTELLI PLEX DEVELOPMENT	0	0	0	0	112
190.10	19010	MS&M	0	0	0	0	0
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0
190.13	19013	SSA	0	0	0	0	0
190.14	19014	SPORTSWORKS	0	0	0	0	0
190.15	19015	SHELBY PEDS	0	0	0	0	0
190.16	19016	RENOVO	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
190.17	19017	I MA	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019	MHCD	1,006	0	49	0	0	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	0	0	0	0	2,876	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	9,721	12	476	0	0	194.00
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)	395,884	22,039	19,226	96,450	150,366	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00590						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00592						5.06
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	79,334					13.00
14.00	01400	0	121,588				14.00
15.00	01500	0	0	92,360			15.00
16.00	01600	0	0	0	97,158		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	25,219	0	0	6,793	1,133,741	30.00
31.00	03100	5,446	0	0	1,146	317,843	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	11,822	0	0	11,335	453,014	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	2,292	0	0	365	32,666	53.00
54.00	05400	0	0	0	8,614	406,722	54.00
56.00	05600	0	0	0	0	0	56.00
56.01	05601	5,026	0	0	4,799	663,074	56.01
57.00	05700	0	0	0	7,803	38,251	57.00
58.00	05800	0	0	0	3,748	13,510	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	13,581	147,185	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	3,332	0	0	1,604	49,511	65.00
65.01	06501	1,907	0	0	1,589	9,015	65.01
66.00	06600	0	0	0	2,183	49,880	66.00
69.00	06900	2,600	0	0	1,849	120,868	69.00
71.00	07100	0	69,305	0	3,640	84,514	71.00
72.00	07200	0	52,283	0	2,721	64,380	72.00
73.00	07300	0	0	92,360	8,383	107,264	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	1,473	0	0	148	195,397	90.00
91.00	09100	10,210	0	0	15,729	282,135	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	1,071	15,103	95.00
97.00	09700	0	0	0	0	0	97.00
100.00	10000	0	0	0	0	0	100.00
101.00	10100	3,311	0	0	57	11,953	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		72,638	121,588	92,360	97,158	4,196,026	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	14,085	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	0	0	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
190.05	19005	0	0	0	0	10,887	190.05
190.06	19006	0	0	0	0	0	190.06
190.07	19007	1,503	0	0	0	7,343	190.07
190.08	19008	0	0	0	0	0	190.08
190.09	19009	85	0	0	0	730	190.09
190.10	19010	0	0	0	0	0	190.10
190.11	19011	0	0	0	0	0	190.11
190.12	19012	0	0	0	0	0	190.12
190.13	19013	0	0	0	0	0	190.13
190.14	19014	0	0	0	0	0	190.14
190.15	19015	0	0	0	0	0	190.15

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/20/2015 1:28 pm		
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal		
			13.00	14.00	15.00	16.00	24.00		
190.16	19016	RENOVO	0	0	0	0	0	0	190.16
190.17	19017	IMA	0	0	0	0	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	0	0	0	0	190.18
190.19	19019	MHCD	0	0	0	0	15,880	15,880	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
192.01	19201	HOSPITALIST	2,198	0	0	0	17,473	19,671	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,910	0	0	0	106,125	109,035	194.00
200.00		Cross Foot Adjustments						0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	79,334	121,588	92,360	97,158	4,368,549	4,658,989	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/20/2015 1:28 pm
Cost Center	Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01160	COMMUNICATIONS			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES			5.03
5.04	00570	ADMINISTRATIVE			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL			5.06
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,133,741	30.00
31.00	03100	INTENSIVE CARE UNIT	0	317,843	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	453,014	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	32,666	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	406,722	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	ONCOLOGY	0	663,074	56.01
57.00	05700	CT SCAN	0	38,251	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,510	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	147,185	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	49,511	65.00
65.01	06501	SLEEP LAB	0	9,015	65.01
66.00	06600	PHYSICAL THERAPY	0	49,880	66.00
69.00	06900	ELECTROCARDIOLOGY	0	120,868	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84,514	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	64,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	107,264	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	195,397	90.00
91.00	09100	EMERGENCY	0	282,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	15,103	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	11,953	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,196,026	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,085	190.00
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	190.01
190.02	19002	SICK CHILD CARE	0	0	190.02
190.03	19003	PRIVATE DUTY	0	0	190.03
190.04	19004	ST. VINCENT'S STRESS	0	0	190.04
190.05	19005	MARKETING	0	10,887	190.05
190.06	19006	MHLIGHTBOUND	0	0	190.06
190.07	19007	I-74 CAMPUS	0	7,343	190.07
190.08	19008	SOUTHEAST OB	0	0	190.08
190.09	19009	INTELLI PLEX DEVELOPMENT	0	730	190.09
190.10	19010	MS&M	0	0	190.10
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	190.11
190.12	19012	BARTLEY ORTHOPEDICS	0	0	190.12
190.13	19013	SSA	0	0	190.13

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150097

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

Worksheet B
Part II
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
190.14	19014	SPORTSWORKS	0	0	190.14
190.15	19015	SHELBY PEDS	0	0	190.15
190.16	19016	RENOVO	0	0	190.16
190.17	19017	I MA	0	0	190.17
190.18	19018	MD SOLUTIONS	0	0	190.18
190.19	19019	MHCD	0	15,880	190.19
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	HOSPITALIST	0	17,473	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	106,125	194.00
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	4,368,549	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

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

Worksheet B-1
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (TELEPHONES)	DATA PROCESSING (HARDWARE)	PURCHASING, RECEIVING, AND STORES (PURCHASING)	
	BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	129,668					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	540	34,988,751				4.00
5.01 01160 COMMUNICATIONS	291	15,000	526			5.01
5.02 00550 DATA PROCESSING	678	1,184,544	25	554		5.02
5.03 00590 PURCHASING, RECEIVING, AND STORES	729	186,366	8	3	2,004,393	5.03
5.04 00570 ADMITTING	1,618	868,965	22	28	22,741	5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE	0	587,942	0	14	14,853	5.05
5.06 00592 OTHER ADMINISTRATIVE AND GENERAL	10,613	3,672,498	36	44	36,302	5.06
7.00 00700 OPERATION OF PLANT	11,314	754,273	14	15	1,186	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	555	24,216	0	1	0	8.00
9.00 00900 HOUSEKEEPING	257	715,946	4	26	20,852	9.00
10.00 01000 DIETARY	2,462	163,445	9	18	18,329	10.00
11.00 01100 CAFETERIA	3,899	352,305	0	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	1,683	1,018,953	44	14	35,544	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	3,181	0	5	4	53,770	14.00
15.00 01500 PHARMACY	1,448	855,224	9	11	21,422	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2,203	667,187	16	15	14,354	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	24,273	4,742,577	76	84	276,575	30.00
31.00 03100 INTENSIVE CARE UNIT	7,433	978,806	19	18	120,496	31.00
41.00 04100 SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	9,738	2,463,394	49	41	468,889	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	471	2,122,430	0	5	109,258	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	9,293	1,865,137	28	31	52,887	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
56.01 05601 ONCOLOGY	16,618	1,055,586	50	17	65,189	56.01
57.00 05700 CT SCAN	400	357,348	0	4	24,930	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	285,129	0	3	8,801	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	2,005	1,755,384	22	39	196,003	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	836	737,820	3	11	38,259	65.00
65.01 06501 SLEEP LAB	0	377,527	4	6	18,154	65.01
66.00 06600 PHYSICAL THERAPY	630	1,320,761	24	20	27,937	66.00
69.00 06900 ELECTROCARDIOLOGY	2,823	391,335	0	9	43,819	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48,541	0	3	2,608	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	36,293	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	4,997	163,123	16	5	5,813	90.00
91.00 09100 EMERGENCY	5,301	1,990,667	21	32	195,808	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0	36,834	95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
100.00 10000 I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	683,760	0	11	34,738	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	126,289	32,442,482	504	532	1,966,351	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	372	0	0	0	0	190.00
190.01 19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0	190.01
190.02 19002 SICK CHILD CARE	0	0	0	0	0	190.02
190.03 19003 PRIVATE DUTY	0	0	0	0	0	190.03
190.04 19004 ST. VINCENT'S STRESS	0	0	0	0	0	190.04
190.05 19005 MARKETING	192	204,267	0	0	0	190.05
190.06 19006 MHLIGHTBOUND	0	0	0	0	0	190.06
190.07 19007 I-74 CAMPUS	0	144,605	1	5	0	190.07
190.08 19008 SOUTHEAST OB	0	0	0	0	0	190.08
190.09 19009 INTELLI PLEX DEVELOPMENT	0	11,649	0	0	26	190.09
190.10 19010 MS&M	0	0	0	0	0	190.10
190.11 19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

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

Worksheet B-1

Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (TELEPHONES)	DATA PROCESSING (HARDWARE)	PURCHASING, RECEIVING, AND STORES (PURCHASING)	
	BLDG & FIXT (SQUARE FEET)						
	1.00		4.00	5.01	5.02	5.03	
190.12 19012 BARTLEY ORTHOPEDICS	0		0	0	0	0	190.12
190.13 19013 SSA	0		0	0	0	0	190.13
190.14 19014 SPORTSWORKS	0		0	0	0	0	190.14
190.15 19015 SHELBY PEDS	0		0	0	0	0	190.15
190.16 19016 RENOVO	0		0	0	0	0	190.16
190.17 19017 IMA	0		0	0	0	0	190.17
190.18 19018 MD SOLUTIONS	0		0	0	0	0	190.18
190.19 19019 MHCD	264		0	0	0	0	190.19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0		0	0	0	0	192.00
192.01 19201 HOSPITALIST	0		1,614,023	0	7	314	192.01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	2,551		571,725	21	10	37,702	194.00
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4,368,549		8,279,320	25,513	3,627,470	371,658	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	33.690263		0.236628	48.503802	6,547.779783	0.185422	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			18,193	9,812	23,924	24,936	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000520	18.653992	43.184116	0.012441	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

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

Worksheet B-1

Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		ADMINISTRATIVE (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.04	5.05	5A.06	5.06	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00590	PURCHASING, RECEIVING, AND STORES					5.03
5.04	00570	ADMINISTRATIVE	242,087,050				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	242,087,050			5.05
5.06	00592	OTHER ADMINISTRATIVE AND GENERAL	0	0	-8,503,359	69,750,499	5.06
7.00	00700	OPERATION OF PLANT	0	0	0	2,577,683	103,885
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	225,167	555
9.00	00900	HOUSEKEEPING	0	0	0	1,493,077	257
10.00	01000	DIETARY	0	0	0	462,990	2,462
11.00	01100	CAFETERIA	0	0	0	623,507	3,899
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,528,436	1,683
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	148,000	3,181
15.00	01500	PHARMACY	0	0	0	6,149,105	1,448
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,269,571	2,203
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,482,900	14,482,900	0	8,328,193	24,273
31.00	03100	INTENSIVE CARE UNIT	2,886,999	2,886,999	0	1,920,207	7,433
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	28,551,087	28,551,087	0	5,321,105	9,738
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	918,687	918,687	0	1,223,636	471
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,698,626	21,698,626	0	4,883,591	9,293
56.00	05600	RADIOLOGY-SOTOPE	0	0	0	0	0
56.01	05601	ONCOLOGY	12,088,263	12,088,263	0	2,780,593	16,618
57.00	05700	CT SCAN	19,655,928	19,655,928	0	1,465,903	400
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,441,082	9,441,082	0	1,035,399	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	34,208,336	34,208,336	0	5,554,687	2,005
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	4,041,045	4,041,045	0	1,221,253	836
65.01	06501	SLEEP LAB	4,002,489	4,002,489	0	731,638	0
66.00	06600	PHYSICAL THERAPY	5,498,135	5,498,135	0	2,374,702	630
69.00	06900	ELECTROCARDIOLOGY	4,657,902	4,657,902	0	840,408	2,823
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,167,857	9,167,857	0	1,638,646	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,854,657	6,854,657	0	1,390,909	0
73.00	07300	DRUGS CHARGED TO PATIENTS	21,114,631	21,114,631	0	279,621	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	372,488	372,488	0	516,692	4,997
91.00	09100	EMERGENCY	39,605,790	39,605,790	0	4,257,246	5,301
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,697,177	2,697,177	0	2,487,471	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	142,971	142,971	0	1,402,108	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	242,087,050	242,087,050	-8,503,359	64,131,544	100,506
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	12,533	372
190.01	19001	SHELBY COUNTY MEDICAL CENTER	0	0	0	0	0
190.02	19002	SICK CHILD CARE	0	0	0	0	0
190.03	19003	PRIVATE DUTY	0	0	0	0	0
190.04	19004	ST. VINCENT'S STRESS	0	0	0	0	0
190.05	19005	MARKETING	0	0	0	459,677	192
190.06	19006	MH LIGHTBOUND	0	0	0	0	0
190.07	19007	I-74 CAMPUS	0	0	0	685,598	0
190.08	19008	SOUTHEAST OB	0	0	0	0	0
190.09	19009	INTELLI PLEX DEVELOPMENT	0	0	0	101,462	0
190.10	19010	MS&M	0	0	0	0	0
190.11	19011	OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0
190.12	19012	BARTLEY ORTHOPEDICS	0	0	0	0	0
190.13	19013	SSA	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

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

Worksheet B-1

Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		ADMINISTRATIVE (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.04	5.05	5A.06	5.06	7.00	
190.14	19014 SPORTSWORKS	0	0	0	0	0	190.14
190.15	19015 SHELBY PEDS	0	0	0	0	0	190.15
190.16	19016 RENOVO	0	0	0	1	0	190.16
190.17	19017 IMA	0	0	0	0	0	190.17
190.18	19018 MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019 MHCD	0	0	0	1,141,224	264	190.19
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 HOSPITALIST	0	0	0	2,165,525	0	192.01
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	1,052,935	2,551	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,430,290	1,775,774		8,503,359	2,891,931	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.005908	0.007335		0.121911	27.837811	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	56,865	1,096		362,489	395,884	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000235	0.000005		0.005197	3.810791	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

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

Worksheet B-1

Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00590						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00592						5.06
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000						30.00
31.00	03100						31.00
41.00	04100						41.00
42.00	04200						42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000						50.00
52.00	05200						52.00
53.00	05300						53.00
54.00	05400						54.00
56.00	05600						56.00
56.01	05601						56.01
57.00	05700						57.00
58.00	05800						58.00
59.00	05900						59.00
60.00	06000						60.00
60.01	06001						60.01
65.00	06500						65.00
65.01	06501						65.01
66.00	06600						66.00
69.00	06900						69.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800						88.00
89.00	08900						89.00
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500						95.00
97.00	09700						97.00
100.00	10000						100.00
101.00	10100						101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
190.01	19001						190.01
190.02	19002						190.02
190.03	19003						190.03
190.04	19004						190.04
190.05	19005						190.05
190.06	19006						190.06
190.07	19007						190.07
190.08	19008						190.08
190.09	19009						190.09
190.10	19010						190.10
190.11	19011						190.11
190.12	19012						190.12
190.13	19013						190.13
190.14	19014						190.14

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

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

Worksheet B-1

Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	
		8.00	9.00	10.00	11.00	13.00	
190.15	19015 SHELBY PEDS	0	0	0	0	0	190.15
190.16	19016 RENOV0	0	0	0	0	0	190.16
190.17	19017 IMA	0	0	0	0	0	190.17
190.18	19018 MD SOLUTIONS	0	0	0	0	0	190.18
190.19	19019 MHCD	0	264	0	0	0	190.19
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 HOSPITALIST	0	0	0	15,091	15,091	192.01
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	196	2,551	0	0	19,979	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	268,067	1,682,254	628,153	871,695	1,821,343	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.735536	16.320996	60.644236	1.104740	3.343656	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	22,039	19,226	96,450	150,366	79,334	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.060472	0.186528	9.311643	0.190566	0.145643	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

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

Worksheet B-1
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
4.00	00400				4.00
5.01	01160				5.01
5.02	00550				5.02
5.03	00590				5.03
5.04	00570				5.04
5.05	00580				5.05
5.06	00592				5.06
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	244,713,787	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	0	17,109,637	30.00
31.00	03100	0	0	2,886,999	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	0	28,551,087	50.00
52.00	05200	0	0	0	52.00
53.00	05300	0	0	918,687	53.00
54.00	05400	0	0	21,698,626	54.00
56.00	05600	0	0	0	56.00
56.01	05601	0	0	12,088,263	56.01
57.00	05700	0	0	19,655,928	57.00
58.00	05800	0	0	9,441,082	58.00
59.00	05900	0	0	0	59.00
60.00	06000	0	0	34,208,336	60.00
60.01	06001	0	0	0	60.01
65.00	06500	0	0	4,041,045	65.00
65.01	06501	0	0	4,002,489	65.01
66.00	06600	0	0	5,498,135	66.00
69.00	06900	0	0	4,657,902	69.00
71.00	07100	57	0	9,167,857	71.00
72.00	07200	43	0	6,854,657	72.00
73.00	07300	0	100	21,114,631	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	0	0	372,488	90.00
91.00	09100	0	0	39,605,790	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	0	0	2,697,177	95.00
97.00	09700	0	0	0	97.00
100.00	10000	0	0	0	100.00
101.00	10100	0	0	142,971	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	0	0	0	113.00
118.00		100	100	244,713,787	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
190.01	19001	0	0	0	190.01
190.02	19002	0	0	0	190.02
190.03	19003	0	0	0	190.03
190.04	19004	0	0	0	190.04
190.05	19005	0	0	0	190.05
190.06	19006	0	0	0	190.06
190.07	19007	0	0	0	190.07
190.08	19008	0	0	0	190.08
190.09	19009	0	0	0	190.09
190.10	19010	0	0	0	190.10
190.11	19011	0	0	0	190.11
190.12	19012	0	0	0	190.12
190.13	19013	0	0	0	190.13

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150097

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		14.00	15.00	16.00	
190.14	19014 SPORTSWORKS	0	0	0	190.14
190.15	19015 SHELBY PEDS	0	0	0	190.15
190.16	19016 RENOVO	0	0	0	190.16
190.17	19017 IMA	0	0	0	190.17
190.18	19018 MD SOLUTIONS	0	0	0	190.18
190.19	19019 MHCD	0	0	0	190.19
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201 HOSPITALIST	0	0	0	192.01
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	306,512	6,988,638	1,556,771	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3,065.120000	69,886.380000	0.006362	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	121,588	92,360	97,158	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1,215.880000	923.600000	0.000397	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150097

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

Worksheet C
Part I
Date/Time Prepared:
5/20/2015 1:28 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		11,970,431	0	11,970,431	30.00
31.00	03100 INTENSIVE CARE UNIT		2,740,795	0	2,740,795	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,980,022	0	6,980,022	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		1,469,459	208,432	1,677,891	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,123,704	0	6,123,704	54.00
56.00	05600 RADIOISOTOPE		0	0	0	56.00
56.01	05601 ONCOLOGY		4,083,834	7,414	4,091,248	56.01
57.00	05700 CT SCAN		1,801,060	0	1,801,060	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,231,709	0	1,231,709	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		6,627,994	0	6,627,994	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,534,537	0	1,534,537	65.00
65.01	06501 SLEEP LAB	0	890,072	0	890,072	65.01
66.00	06600 PHYSICAL THERAPY	0	2,773,101	3,381	2,776,482	66.00
69.00	06900 ELECTROCARDIOLOGY		1,176,583	0	1,176,583	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,075,313	0	2,075,313	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		1,738,686	0	1,738,686	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		7,436,679	0	7,436,679	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		848,650	72,673	921,323	90.00
91.00	09100 EMERGENCY		5,650,900	385,486	6,036,386	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,105,158	0	1,105,158	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		2,807,880	0	2,807,880	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0	0	0	97.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY		1,649,971	0	1,649,971	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		72,716,538	677,386	73,393,924	200.00
201.00	Less Observation Beds		1,105,158		1,105,158	201.00
202.00	Total (see instructions)		71,611,380	677,386	72,288,766	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150097

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

Worksheet C
Part I
Date/Time Prepared:
5/20/2015 1:28 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			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,463,130		14,463,130		30.00
31.00	03100	INTENSIVE CARE UNIT	2,886,999		2,886,999		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,916,813	20,634,274	28,551,087	0.244475	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	251,140	667,547	918,687	1.599521	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,534,774	19,163,852	21,698,626	0.282216	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
56.01	05601	ONCOLOGY	64,594	12,023,669	12,088,263	0.337835	56.01
57.00	05700	CT SCAN	3,340,756	16,315,172	19,655,928	0.091629	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,017,892	8,423,190	9,441,082	0.130463	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	7,457,249	26,751,087	34,208,336	0.193754	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,233,664	807,381	4,041,045	0.379738	65.00
65.01	06501	SLEEP LAB	5,308	3,997,181	4,002,489	0.222380	65.01
66.00	06600	PHYSICAL THERAPY	870,583	4,627,552	5,498,135	0.504371	66.00
69.00	06900	ELECTROCARDIOLOGY	689,647	3,968,255	4,657,902	0.252599	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,162,686	6,005,171	9,167,857	0.226368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,774,567	2,080,090	6,854,657	0.253650	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,172,029	14,942,602	21,114,631	0.352205	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	606	371,882	372,488	2.278328	90.00
91.00	09100	EMERGENCY	6,035,806	33,569,984	39,605,790	0.142679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,646,507	2,646,507	0.417591	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	160,715	2,536,462	2,697,177	1.041044	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	97.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	142,971	142,971		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	65,038,958	179,674,829	244,713,787		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	65,038,958	179,674,829	244,713,787		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/20/2015 1:28 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
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.244475		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	1.826401		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.282216		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
56.01	05601 ONCOLOGY	0.338448		56.01
57.00	05700 CT SCAN	0.091629		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.130463		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.193754		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.379738		65.00
65.01	06501 SLEEP LAB	0.222380		65.01
66.00	06600 PHYSICAL THERAPY	0.504986		66.00
69.00	06900 ELECTROCARDIOLOGY	0.252599		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.226368		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.253650		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.352205		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	2.473430		90.00
91.00	09100 EMERGENCY	0.152412		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.417591		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	1.041044		95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150097

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

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		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		11,970,431	0	11,970,431	30.00
31.00	03100 INTENSIVE CARE UNIT		2,740,795	0	2,740,795	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,980,022	0	6,980,022	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		1,469,459	208,432	1,677,891	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,123,704	0	6,123,704	54.00
56.00	05600 RADIOISOTOPE		0	0	0	56.00
56.01	05601 ONCOLOGY		4,083,834	7,414	4,091,248	56.01
57.00	05700 CT SCAN		1,801,060	0	1,801,060	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,231,709	0	1,231,709	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		6,627,994	0	6,627,994	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,534,537	0	1,534,537	65.00
65.01	06501 SLEEP LAB	0	890,072	0	890,072	65.01
66.00	06600 PHYSICAL THERAPY	0	2,773,101	3,381	2,776,482	66.00
69.00	06900 ELECTROCARDIOLOGY		1,176,583	0	1,176,583	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,075,313	0	2,075,313	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		1,738,686	0	1,738,686	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		7,436,679	0	7,436,679	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		848,650	72,673	921,323	90.00
91.00	09100 EMERGENCY		5,650,900	385,486	6,036,386	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,105,158	0	1,105,158	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		2,807,880	0	2,807,880	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		0	0	0	97.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY		1,649,971	0	1,649,971	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		72,716,538	677,386	73,393,924	200.00
201.00	Less Observation Beds		1,105,158		1,105,158	201.00
202.00	Total (see instructions)		71,611,380	677,386	72,288,766	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150097

Period:
From 01/01/2014
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Cost Center Description		Charges			Hospital	Cost	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)					Cost or Other Ratio
		6.00	7.00	8.00					9.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	14,463,130		14,463,130			30.00	
31.00	03100	INTENSIVE CARE UNIT	2,886,999		2,886,999			31.00	
41.00	04100	SUBPROVIDER - IRF	0		0			41.00	
42.00	04200	SUBPROVIDER	0		0			42.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	7,916,813	20,634,274	28,551,087	0.244475	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	251,140	667,547	918,687	1.599521	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,534,774	19,163,852	21,698,626	0.282216	0.000000	54.00	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
56.01	05601	ONCOLOGY	64,594	12,023,669	12,088,263	0.337835	0.000000	56.01	
57.00	05700	CT SCAN	3,340,756	16,315,172	19,655,928	0.091629	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,017,892	8,423,190	9,441,082	0.130463	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
60.00	06000	LABORATORY	7,457,249	26,751,087	34,208,336	0.193754	0.000000	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01	
65.00	06500	RESPIRATORY THERAPY	3,233,664	807,381	4,041,045	0.379738	0.000000	65.00	
65.01	06501	SLEEP LAB	5,308	3,997,181	4,002,489	0.222380	0.000000	65.01	
66.00	06600	PHYSICAL THERAPY	870,583	4,627,552	5,498,135	0.504371	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	689,647	3,968,255	4,657,902	0.252599	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,162,686	6,005,171	9,167,857	0.226368	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,774,567	2,080,090	6,854,657	0.253650	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	6,172,029	14,942,602	21,114,631	0.352205	0.000000	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00	
90.00	09000	CLINIC	606	371,882	372,488	2.278328	0.000000	90.00	
91.00	09100	EMERGENCY	6,035,806	33,569,984	39,605,790	0.142679	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,646,507	2,646,507	0.417591	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	160,715	2,536,462	2,697,177	1.041044	0.000000	95.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00	
101.00	10100	HOME HEALTH AGENCY	0	142,971	142,971			101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	65,038,958	179,674,829	244,713,787			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	65,038,958	179,674,829	244,713,787			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150097

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

Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
56.01	05601 ONCOLOGY	0.000000			56.01
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
65.01	06501 SLEEP LAB	0.000000			65.01
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
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
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000			97.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150097

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

Worksheet D
Part I
Date/Time Prepared:
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,133,741	0	1,133,741	10,279	110.30	30.00	
31.00	INTENSIVE CARE UNIT	317,843		317,843	956	332.47	31.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
200.00	Total (lines 30-199)	1,451,584		1,451,584	11,235		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	4,373	482,342					30.00
31.00	INTENSIVE CARE UNIT	514	170,890					31.00
41.00	SUBPROVIDER - IRF	0	0					41.00
42.00	SUBPROVIDER	0	0					42.00
200.00	Total (lines 30-199)	4,887	653,232					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/20/2015 1:28 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	453,014	28,551,087	0.015867	2,562,689	40,662	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	32,666	918,687	0.035557	77,788	2,766	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	406,722	21,698,626	0.018744	1,367,641	25,635	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
56.01	05601 ONCOLOGY	663,074	12,088,263	0.054853	23,954	1,314	56.01
57.00	05700 CT SCAN	38,251	19,655,928	0.001946	1,837,458	3,576	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	13,510	9,441,082	0.001431	572,491	819	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	147,185	34,208,336	0.004303	4,303,435	18,518	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	49,511	4,041,045	0.012252	1,689,300	20,697	65.00
65.01	06501 SLEEP LAB	9,015	4,002,489	0.002252	5,308	12	65.01
66.00	06600 PHYSICAL THERAPY	49,880	5,498,135	0.009072	588,644	5,340	66.00
69.00	06900 ELECTROCARDIOLOGY	120,868	4,657,902	0.025949	659,267	17,107	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	84,514	9,167,857	0.009219	1,814,928	16,732	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	64,380	6,854,657	0.009392	2,250,134	21,133	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	107,264	21,114,631	0.005080	3,158,116	16,043	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	195,397	372,488	0.524573	0	0	90.00
91.00	09100 EMERGENCY	282,135	39,605,790	0.007124	3,167,192	22,563	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	104,672	2,646,507	0.039551	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00	Total (lines 50-199)	2,822,058	224,523,510		24,078,345	212,917	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/20/2015 1:28 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
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	10,279	0.00	4,373	0		30.00
31.00	03100	INTENSIVE CARE UNIT	956	0.00	514	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
200.00		Total (lines 30-199)	11,235		4,887	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150097

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

Worksheet D
Part IV
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
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	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/20/2015 1:28 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	28,551,087	0.000000	0.000000	2,562,689	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	918,687	0.000000	0.000000	77,788	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	21,698,626	0.000000	0.000000	1,367,641	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
56.01	05601 ONCOLOGY	0	12,088,263	0.000000	0.000000	23,954	56.01
57.00	05700 CT SCAN	0	19,655,928	0.000000	0.000000	1,837,458	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	9,441,082	0.000000	0.000000	572,491	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	34,208,336	0.000000	0.000000	4,303,435	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	4,041,045	0.000000	0.000000	1,689,300	65.00
65.01	06501 SLEEP LAB	0	4,002,489	0.000000	0.000000	5,308	65.01
66.00	06600 PHYSICAL THERAPY	0	5,498,135	0.000000	0.000000	588,644	66.00
69.00	06900 ELECTROCARDIOLOGY	0	4,657,902	0.000000	0.000000	659,267	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,167,857	0.000000	0.000000	1,814,928	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6,854,657	0.000000	0.000000	2,250,134	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,114,631	0.000000	0.000000	3,158,116	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	372,488	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	39,605,790	0.000000	0.000000	3,167,192	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,646,507	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	224,523,510			24,078,345	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/20/2015 1:28 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	6,598,352	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	178,160	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,256,307	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
56.01	05601 ONCOLOGY	0	5,112,805	0	56.01
57.00	05700 CT SCAN	0	4,678,617	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,139,907	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	3,635,625	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	358,181	0	65.00
65.01	06501 SLEEP LAB	0	1,351,391	0	65.01
66.00	06600 PHYSICAL THERAPY	0	739	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,892,334	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,364,956	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	980,295	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,995,451	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	7,940,811	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	756,066	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	97.00
200.00	Total (lines 50-199)	0	48,239,997	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/20/2015 1:28 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	0.244475	6,598,352	0	0	1,613,132	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1.599521	178,160	0	0	284,971	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282216	5,256,307	0	0	1,483,414	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	ONCOLOGY	0.337835	5,112,805	0	0	1,727,284	56.01
57.00	05700	CT SCAN	0.091629	4,678,617	0	0	428,697	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.130463	2,139,907	0	0	279,179	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.193754	3,635,625	1,014	0	704,417	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.379738	358,181	0	0	136,015	65.00
65.01	06501	SLEEP LAB	0.222380	1,351,391	0	0	300,522	65.01
66.00	06600	PHYSICAL THERAPY	0.504371	739	0	0	373	66.00
69.00	06900	ELECTROCARDIOLOGY	0.252599	1,892,334	0	0	478,002	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.226368	1,364,956	6,299	0	308,982	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.253650	980,295	0	0	248,652	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352205	5,995,451	0	27,010	2,111,628	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	2.278328	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.142679	7,940,811	0	0	1,132,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.417591	756,066	0	0	315,726	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1.041044		0			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		48,239,997	7,313	27,010	11,553,981	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		48,239,997	7,313	27,010	11,553,981	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/20/2015 1:28 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
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	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
56.01 05601 ONCOLOGY	0	0		56.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	196	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
65.01 06501 SLEEP LAB	0	0		65.01
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,426	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9,513		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
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
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00 Subtotal (see instructions)	1,622	9,513		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	1,622	9,513		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/20/2015 1:28 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)		10,279	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,279	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)		9,330	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)		4,373	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)		11,970,431	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)		11,970,431	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)		11,970,431	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)		1,164.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,092,577	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)		5,092,577	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/20/2015 1:28 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)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,740,795	956	2,866.94	514	1,473,607		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)					5,922,591		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,488,775		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)					653,232		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					212,917		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					866,149		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,622,626		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)					949		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,164.55		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,105,158		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/20/2015 1:28 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,133,741	11,970,431	0.094712	1,105,158	104,672	90.00
91.00	Nursing School cost	0	11,970,431	0.000000	1,105,158	0	91.00
92.00	Allied health cost	0	11,970,431	0.000000	1,105,158	0	92.00
93.00	All other Medical Education	0	11,970,431	0.000000	1,105,158	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 5/20/2015 1:28 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)		10,279	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,279	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)		9,330	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)		745	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)		11,970,431	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)		11,970,431	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)		11,970,431	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)		1,164.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		867,590	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)		867,590	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
Title XIX		Hospital		Cost			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,740,795	956	2,866.94	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)					628,820		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,496,410		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						949	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,164.55	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,105,158	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150097		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/20/2015 1:28 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	1,133,741	11,970,431	0.094712	1,105,158	104,672	90.00
91.00	Nursing School cost	0	11,970,431	0.000000	1,105,158	0	91.00
92.00	Allied health cost	0	11,970,431	0.000000	1,105,158	0	92.00
93.00	All other Medical Education	0	11,970,431	0.000000	1,105,158	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/20/2015 1:28 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		5,346,440	30.00
31.00	03100	INTENSIVE CARE UNIT		1,231,697	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.244475	2,562,689	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	1.826401	77,788	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282216	1,367,641	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
56.01	05601	ONCOLOGY	0.338448	23,954	56.01
57.00	05700	CT SCAN	0.091629	1,837,458	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.130463	572,491	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.193754	4,303,435	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.379738	1,689,300	65.00
65.01	06501	SLEEP LAB	0.222380	5,308	65.01
66.00	06600	PHYSICAL THERAPY	0.504986	588,644	66.00
69.00	06900	ELECTROCARDIOLOGY	0.252599	659,267	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.226368	1,814,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.253650	2,250,134	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352205	3,158,116	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	2.473430	0	90.00
91.00	09100	EMERGENCY	0.152412	3,167,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.417591	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		24,078,345	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		24,078,345	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/20/2015 1:28 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		1,561,375	30.00
31.00	03100	INTENSIVE CARE UNIT		159,105	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.244475	493,225	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	1.599521	29,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.282216	151,413	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
56.01	05601	ONCOLOGY	0.337835	10,473	56.01
57.00	05700	CT SCAN	0.091629	190,954	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.130463	56,275	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.193754	519,477	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.379738	174,589	65.00
65.01	06501	SLEEP LAB	0.222380	0	65.01
66.00	06600	PHYSICAL THERAPY	0.504371	20,194	66.00
69.00	06900	ELECTROCARDIOLOGY	0.252599	30,245	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.226368	216,389	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.253650	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352205	443,030	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	2.278328	0	90.00
91.00	09100	EMERGENCY	0.142679	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.417591	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		2,335,858	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		2,335,858	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/20/2015 1:28 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)		6,155,188	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,068,384	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)		173,957	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)		58.40	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)		4.40	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.27	31.00
32.00	Sum of lines 30 and 31		23.67	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.75	33.00
34.00	Disproportionate share adjustment (see instructions)		179,891	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/20/2015 1:28 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)		0.000055010	0.000054352	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		497,641	415,662	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		372,208	104,770	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		476,978		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)		9,054,398		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)		9,054,398		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		657,552		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		868		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)		9,712,818		59.00
60.00	Primary payer payments		4,143		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,708,675		61.00
62.00	Deductibles billed to program beneficiaries		1,129,184		62.00
63.00	Coinurance billed to program beneficiaries		0		63.00
64.00	Allowable bad debts (see instructions)		10,575		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		6,874		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		-36,824		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,586,365		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)		25,770		70.93
70.94	HRR adjustment amount (see instructions)		-1,034		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/20/2015 1:28 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)	2014	123,922		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2015	47,725		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)		8,782,748		71.00
71.01	Sequestration adjustment (see instructions)		175,655		71.01
72.00	Interim payments		8,592,635		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)		14,458		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1,625,267		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150097

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/20/2015 1:28 pm

		Title XVIII		Hospital		PPS		
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6,155,188	0	6,155,188	0	6,155,188	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,068,384	0	0	2,068,384	2,068,384	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	173,957	0	149,999	23,958	173,957	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0875	0.0875	0.0875	0.0875		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	179,891	0	134,645	45,246	179,891	11.00
11.01	Uncompensated care payments	36.00	476,978	0	372,208	104,770	476,978	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,054,398	0	6,812,040	2,242,358	9,054,398	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,054,398	0	6,812,040	2,242,358	9,054,398	15.00
16.00	Payment for inpatient program capital	50.00	657,552	0	492,108	165,444	657,552	16.00
17.00	Special add-on payments for new technologies	54.00	868	0	868	0	868	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150097

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/20/2015 1:28 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	7,305,016	2,407,802	9,712,818	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	657,439	0	491,995	165,444	657,439	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	113	0	113	0	113	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	657,552	0	492,108	165,444	657,552	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				0.016964	0.019821		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			123,922		123,922	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				47,725	47,725	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: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/20/2015 1:28 pm
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		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	6,155,188	6,155,188		6,155,188	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,068,384		2,068,384	2,068,384	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	173,957	149,999	23,958	173,957	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	0.0875	0.0875	0.0875		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	179,891	134,645	45,246	179,891	11.00
11.01	Uncompensated care payments	36.00	476,978	372,208	104,770	476,978	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	9,054,398	6,812,040	2,242,358	9,054,398	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	9,054,398	6,812,040	2,242,358	9,054,398	15.00
16.00	Payment for inpatient program capital	50.00	657,552	492,108	165,444	657,552	16.00
17.00	Special add-on payments for new technologies	54.00	868	868	0	868	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			7,305,016	2,407,802	9,712,818	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 150097

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/20/2015 1:28 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	657,439	491,995	165,444	657,439	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	113	113	0	113	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	657,552	492,108	165,444	657,552	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	123,922	123,922		123,922	28.00	
29.00	Low volume adjustment on or after October 1	70.97	47,725		47,725	47,725	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	25,770	22,143	3,627	25,770	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-1,034	0	-1,034	-1,034	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: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/20/2015 1:28 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		11,135	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		11,553,981	2.00
3.00	PPS payments		9,137,815	3.00
4.00	Outlier payment (see instructions)		20,514	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)		11,135	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		34,323	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)		34,323	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)		34,323	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		23,188	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)		11,135	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		9,158,329	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		1,260	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,031,426	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		7,136,778	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		7,136,778	30.00
31.00	Primary payer payments		367	31.00
32.00	Subtotal (line 30 minus line 31)		7,136,411	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)		216,615	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		140,800	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		72,518	36.00
37.00	Subtotal (see instructions)		7,277,211	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,277,211	40.00
40.01	Sequestration adjustment (see instructions)		145,544	40.01
41.00	Interim payments		7,193,621	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-61,954	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: 150097

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

Worksheet E-1
Part I
Date/Time Prepared:
5/20/2015 1:28 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		8,532,415		6,991,334	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	07/10/2014	32,500	07/10/2014	52,600	3.01	
3.02		12/31/2014	27,720	12/31/2014	149,687	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)		60,220		202,287	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)		8,592,635		7,193,621	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		14,458		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		61,954	6.02	
7.00	Total Medicare program liability (see instructions)		8,607,093		7,131,667	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: 150097

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

Worksheet E-1
Part II
Date/Time Prepared:
5/20/2015 1:28 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			2,790 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			4,887 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,043 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			10,286 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			244,713,787 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6,323,511 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)			344,457 8.00
9.00	Sequestration adjustment amount (see instructions)			6,889 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			337,568 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			348,390 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)			-10,822 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/20/2015 1:28 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,496,410		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)		1,496,410	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,496,410	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		1,720,480		8.00
9.00	Ancillary service charges		2,335,858	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)		4,056,338	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)		4,056,338	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,559,928	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,496,410	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,496,410	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,496,410	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)		1,496,410	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,496,410	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,496,410	0	40.00
41.00	Interim payments		2,271,034	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-774,624	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: 150097

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

Worksheet G

Date/Time Prepared:
5/20/2015 1:28 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	5,453,621	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	26,383,265	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-18,085,073	0	0	0	6.00
7.00	Inventory	12,962,888	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	908,479	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	27,623,180	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,737,322	0	0	0	12.00
13.00	Land improvements	5,939,611	0	0	0	13.00
14.00	Accumulated depreciation	-1,887,580	0	0	0	14.00
15.00	Buildings	38,762,854	0	0	0	15.00
16.00	Accumulated depreciation	-23,455,685	0	0	0	16.00
17.00	Leasehold improvements	498,632	0	0	0	17.00
18.00	Accumulated depreciation	-458,683	0	0	0	18.00
19.00	Fixed equipment	1,731,959	0	0	0	19.00
20.00	Accumulated depreciation	-1,073,433	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	33,250,141	0	0	0	23.00
24.00	Accumulated depreciation	-26,974,761	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)	28,070,377	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	156,842,144	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	156,842,144	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	212,535,701	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,216,122	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,239,974	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,060,610	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,516,706	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	80,631,717	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	80,631,717	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	94,148,423	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	118,387,278				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)	118,387,278	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	212,535,701	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150097

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

Worksheet G-1

Date/Time Prepared:
5/20/2015 1:28 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		94,080,218		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		24,307,060			2.00
3.00	Total (sum of line 1 and line 2)		118,387,278		0	3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		118,387,278		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)		118,387,278		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150097

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/20/2015 1:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	16,479,059		16,479,059	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16,479,059		16,479,059	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,181,828		3,181,828	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,181,828		3,181,828	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	19,660,887		19,660,887	17.00
18.00	Ancillary services	42,977,498	142,772,532	185,750,030	18.00
19.00	Outpatient services	6,036,412	33,941,866	39,978,278	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		142,971	142,971	22.00
23.00	AMBULANCE SERVICES	160,715	2,536,462	2,697,177	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MISC OTHER	2,979,472	5,608,883	8,588,355	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	71,814,984	185,002,714	256,817,698	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		85,256,469		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)		85,256,469		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150097

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

Worksheet G-3

Date/Time Prepared:
5/20/2015 1:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	256,817,698	1.00
2.00	Less contractual allowances and discounts on patients' accounts	143,791,674	2.00
3.00	Net patient revenues (line 1 minus line 2)	113,026,024	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	85,256,469	4.00
5.00	Net income from service to patients (line 3 minus line 4)	27,769,555	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	2,256,856	24.00
24.01	INVESTMENT INCOME	2,601,201	24.01
24.02	OTHER NONOPERATING & MISC REVENUE	251,738	24.02
25.00	Total other income (sum of lines 6-24)	5,109,795	25.00
26.00	Total (line 5 plus line 25)	32,879,350	26.00
27.00	LOSS ON IMPAIRMENT	2,400,000	27.00
27.01	TRANSFERS	6,172,290	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	8,572,290	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	24,307,060	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150097

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

Worksheet H

HHA CCN: 157418

Date/Time Prepared: 5/20/2015 1:28 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	113,896	0	0	0	190,894	304,790	5.00
HHA REIMBURSABLE SERVICES							
6.00	462,867	0	0	0	0	462,867	6.00
7.00	0	0	0	0	257,816	257,816	7.00
8.00	50,892	0	0	0	0	50,892	8.00
9.00	4,754	0	0	0	0	4,754	9.00
10.00	0	0	0	0	0	0	10.00
11.00	51,351	0	0	0	0	51,351	11.00
12.00	0	0	0	0	28,563	28,563	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	683,760	0	0	0	477,273	1,161,033	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	304,790	-1,083	303,707			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	462,867	0	462,867			6.00
7.00	0	257,816	0	257,816			7.00
8.00	0	50,892	0	50,892			8.00
9.00	0	4,754	0	4,754			9.00
10.00	0	0	0	0			10.00
11.00	0	51,351	0	51,351			11.00
12.00	0	28,563	0	28,563			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	0	1,161,033	-1,083	1,159,950			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet H-1 Part I Date/Time Prepared: 5/20/2015 1:28 pm
		HHA CCN: 157418	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	303,707	0	0	0	303,707	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	462,867	0	0	0	462,867	6.00	
7.00	Physical Therapy	257,816	0	0	0	257,816	7.00	
8.00	Occupational Therapy	50,892	0	0	0	50,892	8.00	
9.00	Speech Pathology	4,754	0	0	0	4,754	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	51,351	0	0	0	51,351	11.00	
12.00	Supplies (see instructions)	28,563	0	0	0	28,563	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	1,159,950	0	0	0	1,159,950	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	303,707					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	164,178	627,045				6.00	
7.00	Physical Therapy	91,447	349,263				7.00	
8.00	Occupational Therapy	18,051	68,943				8.00	
9.00	Speech Pathology	1,686	6,440				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	18,214	69,565				11.00	
12.00	Supplies (see instructions)	10,131	38,694				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		1,159,950				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150097

Period: From 01/01/2014

Worksheet H-1

HHA CCN: 157418

To 12/31/2014

Part II
Date/Time Prepared:
5/20/2015 1:28 pm

Home Health
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-303,707	856,243
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	462,867
7.00	Physical Therapy	0	0	0	0	0	257,816
8.00	Occupational Therapy	0	0	0	0	0	50,892
9.00	Speech Pathology	0	0	0	0	0	4,754
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	51,351
12.00	Supplies (see instructions)	0	0	0	0	0	28,563
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-303,707	856,243
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		303,707
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.354697

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150097

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

Worksheet H-2 Part I

HHA CCN: 157418

Date/Time Prepared: 5/20/2015 1:28 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	PURCHASING, RECEIVING, AND STORES	
		BLDG & FIXT						
	0	1.00		4.00	5.01	5.02	5.03	
1.00 Administrative and General	0	0	0	161,797	0	72,026	6,441	1.00
2.00 Skilled Nursing Care	627,045	0	0	0	0	0	0	2.00
3.00 Physical Therapy	349,263	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	68,943	0	0	0	0	0	0	4.00
5.00 Speech Pathology	6,440	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	69,565	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	38,694	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	1,159,950	0	0	161,797	0	72,026	6,441	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00
Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
	5.04	5.05	5A.05	5.06	7.00	8.00		
1.00 Administrative and General	845	1,049	242,158	29,522	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	627,045	76,443	0	0	0	2.00
3.00 Physical Therapy	0	0	349,263	42,579	0	0	0	3.00
4.00 Occupational Therapy	0	0	68,943	8,405	0	0	0	4.00
5.00 Speech Pathology	0	0	6,440	785	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	69,565	8,481	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	38,694	4,717	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	845	1,049	1,402,108	170,932	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150097

Period: From 01/01/2014

Worksheet H-2

HHA CCN: 157418

To 12/31/2014

Part I
Date/Time Prepared:
5/20/2015 1:28 pm

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	76,021	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	76,021	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part I)	Total HHA Costs		
	16.00	24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	910	348,611	0	348,611	0	0	1.00
2.00	Skilled Nursing Care	0	703,488	0	703,488	188,453	891,941	2.00
3.00	Physical Therapy	0	391,842	0	391,842	104,967	496,809	3.00
4.00	Occupational Therapy	0	77,348	0	77,348	20,720	98,068	4.00
5.00	Speech Pathology	0	7,225	0	7,225	1,935	9,160	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	78,046	0	78,046	20,907	98,953	7.00
8.00	Supplies (see instructions)	0	43,411	0	43,411	11,629	55,040	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	910	1,649,971	0	1,649,971	348,611	1,649,971	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.267882		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150097
HHA CCN: 157418

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

Worksheet H-2 Part II
Date/Time Prepared: 5/20/2015 1:28 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (TELEPHONES)	DATA PROCESSING (HARDWARE)	PURCHASING, RECEIVING, AND STORES (PURCHASING)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	0	683,760	0	11	34,738	142,971	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	0	683,760	0	11	34,738	142,971	20.00	
21.00 Total cost to be allocated	0	161,797	0	72,026	6,441	845	21.00	
22.00 Unit cost multiplier	0.000000	0.236628	0.000000	6,547.818182	0.185417	0.005910	22.00	
Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)		
	5.05	5A.06	5.06	7.00	8.00	9.00		
1.00 Administrative and General	142,971	0	242,158	0	0	0	1.00	
2.00 Skilled Nursing Care	0	0	627,045	0	0	0	2.00	
3.00 Physical Therapy	0	0	349,263	0	0	0	3.00	
4.00 Occupational Therapy	0	0	68,943	0	0	0	4.00	
5.00 Speech Pathology	0	0	6,440	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	69,565	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	38,694	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	142,971	0	1,402,108	0	0	0	20.00	
21.00 Total cost to be allocated	1,049	0	170,932	0	0	0	21.00	
22.00 Unit cost multiplier	0.007337	0	0.121911	0.000000	0.000000	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150097
HHA CCN: 157418

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

Worksheet H-2
Part II
Date/Time Prepared:
5/20/2015 1:28 pm
PPS

Cost Center Description	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (100% SUPPLIES)	PHARMACY (100% DRUGS TO PATIENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	10.00	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	22,736	0	0	142,971	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	22,736	0	0	142,971	20.00
21.00 Total cost to be allocated	0	0	76,021	0	0	910	21.00
22.00 Unit cost multiplier	0.000000	0.000000	3.343640	0.000000	0.000000	0.006365	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet H-3 Part I Date/Time Prepared: 5/20/2015 1:28 pm
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Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	891,941		891,941	5,516	161.70	1.00
2.00	Physical Therapy	3.00	496,809	0	496,809	2,685	185.03	2.00
3.00	Occupational Therapy	4.00	98,068	0	98,068	622	157.67	3.00
4.00	Speech Pathology	5.00	9,160	0	9,160	83	110.36	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	98,953		98,953	1,521	65.06	6.00
7.00	Total (sum of lines 1-6)		1,594,931	0	1,594,931	10,427		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		26900	0	0		8.00
8.01	Skilled Nursing Care		50032	0	4,169		8.01
9.00	Physical Therapy		26900	0	0		9.00
9.01	Physical Therapy		50032	0	2,099		9.01
10.00	Occupational Therapy		26900	0	0		10.00
10.01	Occupational Therapy		50032	0	436		10.01
11.00	Speech Pathology		26900	0	0		11.00
11.01	Speech Pathology		50032	0	63		11.01
12.00	Medical Social Services		26900	0	0		12.00
12.01	Medical Social Services		50032	0	50		12.01
13.00	Home Health Aide		26900	0	0		13.00
13.01	Home Health Aide		50032	0	1,329		13.01
14.00	Total (sum of lines 8-13)			0	8,146		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	55,040	0	55,040	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Part A	Part B	Ratio (col. 3 ÷ col. 4)
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4,169		0	674,127	1.00
2.00	Physical Therapy	0	2,099		0	388,378	2.00
3.00	Occupational Therapy	0	436		0	68,744	3.00
4.00	Speech Pathology	0	63		0	6,953	4.00
5.00	Medical Social Services	0	50		0	0	5.00
6.00	Home Health Aide	0	1,329		0	86,465	6.00
7.00	Total (sum of lines 1-6)	0	8,146		0	1,224,667	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150097

Period: From 01/01/2014

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HHA CCN: 157418

To 12/31/2014

Part I
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Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	0	0				15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of col.s. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	674,127							1.00
2.00	Physical Therapy	388,378							2.00
3.00	Occupational Therapy	68,744							3.00
4.00	Speech Pathology	6,953							4.00
5.00	Medical Social Services	0							5.00
6.00	Home Health Aide	86,465							6.00
7.00	Total (sum of lines 1-6)	1,224,667							7.00
Cost Center Description		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150097

Period:

Worksheet H-3

HHA CCN: 157418

From 01/01/2014
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Part II
Date/Time Prepared:
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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00 Physical Therapy	66.00	0.504371	0	0	col. 2, line 2.00	1.00
2.00 Occupational Therapy						2.00
3.00 Speech Pathology						3.00
4.00 Cost of Medical Supplies	71.00	0.226368	0	0	col. 2, line 15.00	4.00
5.00 Cost of Drugs	73.00	0.352205	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150097 HHA CCN: 157418	Period: From 01/01/2014 To 12/31/2014	Worksheet H-4 Part I-II Date/Time Prepared: 5/20/2015 1:28 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	990,354
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	45,788
13.00	Total PPS Reimbursement - LUPA Episodes		0	11,186
14.00	Total PPS Reimbursement - PEP Episodes		0	3,919
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	7,179
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	16
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,058,442
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	1,058,442
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	1,058,442
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	1,058,442
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	1,058,442
31.01	Sequestration adjustment (see instructions)		0	21,168
32.00	Interim payments (see instructions)		0	1,037,211
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	63
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150097
HHA CCN: 157418

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

Worksheet H-5
Date/Time Prepared:
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		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		0		1,037,211	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,037,211	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		63	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,037,274	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/20/2015 1:28 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		657,439	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		113	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)		28.38	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		657,552	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