

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/29/2015 9:45 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2015 Time: 9:45 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF SOUTH BEND, INC (150058) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	150,247	-69,303	-64,097	0	1.00
2.00 Subprovider - IPF	0	90	0	0	0	2.00
3.00 Subprovider - IRF	0	22,168	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	172,505	-69,303	-64,097	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 9:20 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 615 N MICHIGAN ST			PO Box:						1.00	
2.00	City: SOUTH BEND			State: IN		Zip Code: 46601		County: ST. JOSEPH		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		MEMORIAL HOSPITAL OF SOUTH BEND, INC	150058	43780	1	01/01/1984	N	P	P	3.00
4.00	Subprovider - IPF		PSYCHIATRIC UNIT	15S058	43780	4	04/07/2011	N	P	P	4.00
5.00	Subprovider - IRF		REHABILITATION UNIT	15T058	43780	5	01/01/1984	N	P	P	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:		To:			
						1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2014		12/31/2014		20.00	
21.00	Type of Control (see instructions)							2		21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y		Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3		N	23.00
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
			1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		11,886	7,980	0	2,656	7,996	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.		625	320	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 9:20 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N		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.	Y			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	Y			3.00	3.00
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)		16.76	21.76		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)		16.76	27.17		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)		16.76	21.78		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).		19.76	27.17		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)		3.00	5.39		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)		3.00	3.00		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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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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.				Y	70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				N N 0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y	75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				N N 0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00

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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)				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)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
				1.00	2.00
				3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	958,204	447,937	1,705,796	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: 150058		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 9:20 am	
		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	15H013			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: BEACON HEALTH SYSTEM	Contractor's Name: WI PHYS SVCS		Contractor's Number: 08001		141.00	
142.00	Street: 615 N MICHIGAN ST	PO Box:				142.00	
143.00	City: SOUTH BEND	State: IN		Zip Code: 46601		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00	
						1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	N	157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00
161.00	CMHC		N	N	N	N	161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	
		Name		County		State	
		0		1.00		2.00	
						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	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.50	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 9:20 am	
			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: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/29/2015 9:20 am	
		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)	Y	12/01/2011		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	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.	Y			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/15/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		Y	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: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/29/2015 9:20 am	
	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.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DEBRA	DEGUCZ		41.00
42.00	Enter the employer/company name of the cost report preparer.	BEACON HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	574-647-3843	DDEGUCZ@BEACONHEALTHSYSTEM.ORG		43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/15/2015		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT ANALYST	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: 150058

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2015 9:20 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	324	118,260	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)		324	118,260	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
8.01 NEONATAL INTENSIVE CARE UNIT	31.01	36	13,140	0.00	0	8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		392	143,080	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00 SUBPROVIDER - IRF	41.00	20	7,300		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		436				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)		9	3,285			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: 150058

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2015 9:20 am

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)	24,387	11,784	76,011			1.00
2.00 HMO and other (see instructions)	8,634	18,539				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	320				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)	24,387	11,784	76,011			7.00
8.00 INTENSIVE CARE UNIT	3,055	0	7,156			8.00
8.01 NEONATAL INTENSIVE CARE UNIT	0	0	7,978			8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	4,725			13.00
14.00 Total (see instructions)	27,442	11,784	95,870	27.17	2,183.21	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	3,418	1,431	5,041	0.00	32.30	16.00
17.00 SUBPROVIDER - IRF	1,424	625	4,212	0.00	23.55	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				27.17	2,239.06	27.00
28.00 Observation Bed Days		0	8,070			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			1,426			30.00
31.00 Employee discount days - IRF			43			31.00
32.00 Labor & delivery days (see instructions)	0	195	475			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: 150058

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2015 9:20 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	5,234	1,672	18,568	1.00
2.00	HMO and other (see instructions)			1,690	3,008		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
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
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)	89.28	0	5,234	1,672	18,568	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	287	118	412	16.00
17.00	SUBPROVIDER - IRF	0.00	0	95	26	244	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	89.28					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: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 9:20 am			
	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	135,342,237	0	135,342,237	4,939,787.00	27.40	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		2,002,709	0	2,002,709	16,930.70	118.29	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	2,134,189	2,134,189	56,520.00	37.76	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)		6,780,940	0	6,780,940	398,707.06	17.01	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		2,720,143	0	2,720,143	73,818.79	36.85	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		1,694,191	0	1,694,191	12,061.00	140.47	13.00
14.00	Home office salaries & wage-related costs		12,920,230	0	12,920,230	245,002.00	52.74	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)		36,408,092	0	36,408,092			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,952,170	0	1,952,170			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		209,606	0	209,606			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		393,910	0	393,910			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	370,027	0	370,027	8,312.00	44.52	26.00
27.00	Administrative & General	5.00	7,289,833	0	7,289,833	253,454.00	28.76	27.00
28.00	Administrative & General under contract (see inst.)		733,410	0	733,410	2,225.00	329.62	28.00
29.00	Maintenance & Repairs	6.00	577,676	0	577,676	17,118.00	33.75	29.00
30.00	Operation of Plant	7.00	2,657,034	0	2,657,034	118,160.00	22.49	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	3,098,321	0	3,098,321	184,562.00	16.79	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,951,304	-1,229,693	1,721,611	112,188.00	15.35	34.00
35.00	Dietary under contract (see instructions)		0	0	0	60,409.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,229,693	1,229,693	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,272,141	0	1,272,141	47,358.00	26.86	38.00
39.00	Central Services and Supply	14.00	1,932,438	0	1,932,438	96,256.00	20.08	39.00
40.00	Pharmacy	15.00	5,806,282	0	5,806,282	148,840.00	39.01	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150058

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2015 9:20 am

	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	2,243,795	0	2,243,795	99,522.00	22.55	41.00
42.00	Social Service	17.00	2,775,705	0	2,775,705	68,263.00	40.66	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part III Date/Time Prepared: 5/29/2015 9:20 am
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	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	134,072,938	-2,134,189	131,938,749	4,928,970.30	26.77	1.00
2.00	Excluded area salaries (see instructions)	6,780,940	0	6,780,940	398,707.06	17.01	2.00
3.00	Subtotal salaries (line 1 minus line 2)	127,291,998	-2,134,189	125,157,809	4,530,263.24	27.63	3.00
4.00	Subtotal other wages & related costs (see inst.)	17,334,564	0	17,334,564	330,881.79	52.39	4.00
5.00	Subtotal wage-related costs (see inst.)	36,408,092	0	36,408,092	0.00	29.09	5.00
6.00	Total (sum of lines 3 thru 5)	181,034,654	-2,134,189	178,900,465	4,861,145.03	36.80	6.00
7.00	Total overhead cost (see instructions)	31,707,966	0	31,707,966	1,216,667.00	26.06	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2015 9:20 am
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		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	3,957,762	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,055,694	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)	20,429,671	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	285,272	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	152,014	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	342,703	14.00
15.00	'Workers' Compensation Insurance	39,208	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	9,750,981	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	165,295	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	321,040	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	36,499,640	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: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Prepared: 5/29/2015 9:20 am
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Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/29/2015 9:20 am
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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)		0.278120		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		56,528,457		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		4,044,286		5.00
6.00	Medicaid charges		215,512,481		6.00
7.00	Medicaid cost (line 1 times line 6)		59,938,331		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		81,933		9.00
10.00	Stand-alone SCHIP charges		88,435,462		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		24,595,671		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		24,513,738		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)		145,872		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		851,875		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		236,923		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)		91,051		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		24,604,789		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	18,538,431	2,639,184	21,177,615	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,155,908	734,010	5,889,918	21.00
22.00	Partial payment by patients approved for charity care	91,026	178,047	269,073	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,064,882	555,963	5,620,845	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)		35,599,378		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		589,139		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		35,010,239		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		9,737,048		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		15,357,893		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		39,962,682		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150058

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

Worksheet A
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	0	17,473,361	17,473,361	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	18,683,849	18,683,849	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	370,027	1,126,554	1,496,581	2,268,711	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,289,833	101,781,664	109,071,497	76,178,307	5.00
6.00	00600	MAINTENANCE & REPAIRS	577,676	4,337,077	4,914,753	4,914,753	6.00
7.00	00700	OPERATION OF PLANT	2,657,034	5,729,228	8,386,262	8,376,379	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,678,658	1,678,658	1,678,658	8.00
9.00	00900	HOUSEKEEPING	3,098,321	2,068,735	5,167,056	5,167,056	9.00
10.00	01000	DIETARY	2,951,304	2,844,077	5,795,381	3,380,082	10.00
11.00	01100	CAFETERIA	0	0	2,414,709	2,414,709	11.00
13.00	01300	NURSING ADMINISTRATION	1,272,141	583,015	1,855,156	1,855,156	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,932,438	4,695,367	6,627,805	6,261,016	14.00
15.00	01500	PHARMACY	5,806,282	22,210,455	28,016,737	13,023,416	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,243,795	1,353,125	3,596,920	3,596,920	16.00
17.00	01700	SOCIAL SERVICE	2,775,705	1,075,103	3,850,808	3,847,808	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,134,189	2,134,189	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,526,519	2,399,833	6,926,352	4,792,163	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	89,920	54,122	144,042	144,042	23.00
23.01	02301	PARAMED	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,724,193	13,307,277	43,031,470	42,465,829	30.00
31.00	03100	INTENSIVE CARE UNIT	5,241,541	3,220,186	8,461,727	8,258,983	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	5,040,276	2,063,593	7,103,869	7,055,468	31.01
40.00	04000	SUBPROVIDER - IPF	1,497,796	796,815	2,294,611	2,288,657	40.00
41.00	04100	SUBPROVIDER - IRF	1,417,432	475,772	1,893,204	1,924,885	41.00
43.00	04300	NURSERY	1,219,632	360,122	1,579,754	1,579,297	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,901,860	40,699,230	53,601,090	22,476,047	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,192,675	3,596,692	7,789,367	7,495,952	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,603,607	11,339,343	19,942,950	13,838,541	54.00
57.00	05700	CT SCAN	1,178,487	550,392	1,728,879	1,728,879	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	603,612	603,612	603,612	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,131,171	7,796,521	8,927,692	2,079,348	59.00
60.00	06000	LABORATORY	2,544,362	10,039,733	12,584,095	12,561,611	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,842,555	1,416,351	4,258,906	4,146,567	65.00
66.00	06600	PHYSICAL THERAPY	2,705,567	1,060,576	3,766,143	3,667,797	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,019,747	314,217	1,333,964	1,343,247	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	315,168	69,895	385,063	385,063	66.10
67.00	06700	OCCUPATIONAL THERAPY	1,451,047	363,258	1,814,305	1,814,305	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	196,060	54,462	250,522	250,522	67.10
68.00	06800	SPEECH PATHOLOGY	815,932	213,380	1,029,312	1,026,948	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	158,815	33,410	192,225	192,225	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9,896,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	32,893,878	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,941,651	73.00
76.00	03020	CARDIOLOGY	1,091,590	1,938,025	3,029,615	3,022,036	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	700,485	214,325	914,810	914,550	90.30
90.50	09004	SLEEP DISORDERS CLINIC	578,006	431,298	1,009,304	835,007	90.50
91.00	09100	EMERGENCY	9,407,446	14,798,081	24,205,527	24,083,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	131,566,445	267,693,579	399,260,024	399,961,991	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	740,418	914,296	1,654,714	1,618,478	193.00
193.10	19301	HEALTH PROPERTIES	1,802,973	2,622,407	4,425,380	4,452,744	193.10
193.40	19303	LEIGHTON CENTER	0	0	0	0	193.40
193.50	19305	WELLNESS CENTER	946,126	1,315,209	2,261,335	1,568,240	193.50
193.80	19308	UNUSED SPACE	0	0	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	193.91
193.92	19311	CCOP	0	165	165	165	193.92
193.93	19312	RESEARCH ADMIN	286,275	80,450	366,725	366,725	193.93
200.00		TOTAL (SUM OF LINES 118-199)	135,342,237	272,626,106	407,968,343	407,968,343	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150058

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

Worksheet A
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-3,042,725	14,430,636	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	425,579	19,109,428	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-47,351	2,221,360	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-34,378,474	41,799,833	5.00
6.00	00600	MAINTENANCE & REPAIRS	-153,943	4,760,810	6.00
7.00	00700	OPERATION OF PLANT	-108,271	8,268,108	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,678,658	8.00
9.00	00900	HOUSEKEEPING	-400	5,166,656	9.00
10.00	01000	DIETARY	-170,582	3,209,500	10.00
11.00	01100	CAFETERIA	-1,628,788	785,921	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,855,156	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-80,153	6,180,863	14.00
15.00	01500	PHARMACY	327,287	13,350,703	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-17,130	3,579,790	16.00
17.00	01700	SOCIAL SERVICE	0	3,847,808	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,134,189	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,792,163	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	-13,110	130,932	23.00
23.01	02301	PARAMED ED	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-41,692	42,424,137	30.00
31.00	03100	INTENSIVE CARE UNIT	100	8,259,083	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	-116,879	6,938,589	31.01
40.00	04000	SUBPROVIDER - I PF	0	2,288,657	40.00
41.00	04100	SUBPROVIDER - I RF	0	1,924,885	41.00
43.00	04300	NURSERY	0	1,579,297	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-35,941	22,440,106	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,489,876	6,006,076	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-129,285	13,709,256	54.00
57.00	05700	CT SCAN	0	1,728,879	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	603,612	58.00
59.00	05900	CARDIAC CATHETERIZATION	-5,476	2,073,872	59.00
60.00	06000	LABORATORY	0	12,561,611	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	82	4,146,649	65.00
66.00	06600	PHYSICAL THERAPY	-260,615	3,407,182	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	-418	1,342,829	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	385,063	66.10
67.00	06700	OCCUPATIONAL THERAPY	-67,592	1,746,713	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	250,522	67.10
68.00	06800	SPEECH PATHOLOGY	0	1,026,948	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	192,225	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,896,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,893,878	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-70,233	14,871,418	73.00
76.00	03020	CARDIOLOGY	-55,379	2,966,657	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	914,550	90.30
90.50	09004	SLEEP DISORDERS CLINIC	-6,692	828,315	90.50
91.00	09100	EMERGENCY	-9,585,194	14,498,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-50,753,151	349,208,840	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
193.00	19300	NONPAID WORKERS	0	1,618,478	193.00
193.10	19301	HEALTH PROPERTIES	0	4,452,744	193.10
193.40	19303	LEIGHTON CENTER	0	0	193.40
193.50	19305	WELLNESS CENTER	0	1,568,240	193.50
193.80	19308	UNUSED SPACE	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	0	193.91
193.92	19311	CCOP	0	165	193.92
193.93	19312	RESEARCH ADMIN	0	366,725	193.93
200.00		TOTAL (SUM OF LINES 118-199)	-50,753,151	357,215,192	200.00

RECLASSIFICATIONS

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		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,941,651	1.00	
	O		0	14,941,651		
B - SUPPLIES CHARGED TO PATIENTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	37,933,296	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
	O		0	37,933,296		
C - AMORTIZATION TO CAPITAL						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	73,403	1.00	
	O		0	73,403		
D - INTEREST TO CAPITAL						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,998,430	1.00	
	O		0	4,998,430		
G - PT UTILIZATION FROM H&L						
1.00	PHYSICAL THERAPY EAST BANK	66.01	0	9,283	1.00	
	O		0	9,283		
H - EE UTILIZATION OF H&L						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	542,720	1.00	
	O		0	542,720		
I - MEDICAL DIRECTOR RECLASS						
1.00	SUBPROVIDER - IRF	41.00	0	36,601	1.00	
	O		0	36,601		
O - CAFETERIA FROM DIET SALARIES						
1.00	CAFETERIA	11.00	1,229,693	0	1.00	
	O		1,229,693	0		
V - MEDICAL DIRECTOR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	42,402	1.00	
	O		0	42,402		
W - WORKERS COMP EH&W						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	229,658	1.00	
	O		0	229,658		
X - PROPERTY INSURANCE TO CAPITAL						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	387,859	1.00	
	O		0	387,859		
Y - GARAGE TO A&G						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	151,279	1.00	
	O		0	151,279		
AB - DEPRECIATION TO CAPITAL						
1.00	NEW CAP REL COSTS-BLDG & EQUIP	1.00	0	12,277,610	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	14,990,761	2.00	
	O		0	27,268,371		
BA - IMPLANTS CHARGED TO PATIENTS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	32,893,878	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	O		0	32,893,878		
DA - DACC TP CAPITAL						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	248	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	44,346	2.00	
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	9,883	3.00	

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		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
4.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	590	4.00	
5.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	332,474	5.00	
6.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	51,505	6.00	
7.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	3,000	7.00	
8.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	5,667	8.00	
9.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	6,630	9.00	
10.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	7,180	10.00	
11.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	92,443	11.00	
12.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	2,528,318	12.00	
13.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	84,804	13.00	
14.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	22,484	14.00	
15.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	20,432	15.00	
16.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	434	16.00	
17.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	2,364	17.00	
18.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	7,579	18.00	
19.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	8	19.00	
20.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	174,297	20.00	
21.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	35,776	21.00	
22.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	36,236	22.00	
23.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	85,298	23.00	
24.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	141,092	24.00	
	0		0	3,693,088		
DD - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	4,998,430	1.00	
	0		0	4,998,430		
IR - INTERNS SALARY FROM LN 22 TO LN 21						
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	2,134,189	0	1.00	
	0		2,134,189	0		
OO - CAFETERIA FROM DIET NON-SALARIES						
1.00	CAFETERIA	11.00	0	1,185,016	1.00	
	0		0	1,185,016		
YY - PROPERTIES						
1.00	HEALTH PROPERTIES	193.10	0	263,941	1.00	
	0		0	263,941		
500.00	Grand Total: Increases		3,363,882	129,649,306	500.00	

RECLASSIFICATIONS

Provider CCN: 150058

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

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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	14,941,651	0		1.00
	O		0	14,941,651			
B - SUPPLIES CHARGED TO PATIENTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	34,315	0		1.00
2.00	PHARMACY	15.00	0	165	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	602,376	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	196,114	0		4.00
5.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	41,221	0		5.00
6.00	SUBPROVIDER - IPF	40.00	0	5,954	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	4,920	0		7.00
8.00	NURSERY	43.00	0	457	0		8.00
9.00	OPERATING ROOM	50.00	0	31,032,600	0		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	293,415	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,569,400	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	1,912,834	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	91,907	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	61,311	0		14.00
15.00	HEMATOLOGY ONCOLOGY CLINIC	90.30	0	252	0		15.00
16.00	EMERGENCY	91.00	0	86,055	0		16.00
	O		0	37,933,296			
C - AMORTIZATION TO CAPITAL							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	73,403	11		1.00
	O		0	73,403			
D - INTEREST TO CAPITAL							
1.00	INTEREST EXPENSE	113.00	0	4,998,430	11		1.00
	O		0	4,998,430			
G - PT UTILIZATION FROM H&L							
1.00	WELLNESS CENTER	193.50	0	9,283	0		1.00
	O		0	9,283			
H - EE UTILIZATION OF H&L							
1.00	WELLNESS CENTER	193.50	0	542,720	0		1.00
	O		0	542,720			
I - MEDICAL DIRECTOR RECLASS							
1.00	PHYSICAL THERAPY	66.00	0	36,601	0		1.00
	O		0	36,601			
O - CAFETERIA FROM DIET SALARIES							
1.00	DIETARY	10.00	1,229,693	0	0		1.00
	O		1,229,693	0			
V - MEDICAL DIRECTOR RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,402	0		1.00
	O		0	42,402			
W - WORKERS COMP EH&W							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	229,658	0		1.00
	O		0	229,658			
X - PROPERTY INSURANCE TO CAPITAL							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	387,859	12		1.00
	O		0	387,859			
Y - GARAGE TO A&G							
1.00	HEALTH PROPERTIES	193.10	0	151,279	0		1.00
	O		0	151,279			
AB - DEPRECIATION TO CAPITAL							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,268,371	9		1.00
2.00		0.00	0	0	9		2.00
	O		0	27,268,371			
BA - IMPLANTS CHARGED TO PATIENTS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,691	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	4,850,706	0		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	28,036,481	0		3.00
	O		0	32,893,878			
DA - DACC TP CAPITAL							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	248	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	44,346	10		2.00
3.00	OPERATION OF PLANT	7.00	0	9,883	10		3.00
4.00	DIETARY	10.00	0	590	10		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	332,474	10		5.00
6.00	PHARMACY	15.00	0	51,505	10		6.00
7.00	SOCIAL SERVICE	17.00	0	3,000	10		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	5,667	10		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	6,630	10		9.00
10.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	7,180	10		10.00
11.00	OPERATING ROOM	50.00	0	92,443	10		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,528,318	10		12.00

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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	CARDIAC CATHETERIZATION	59.00	0	84,804	10	13.00	
14.00	LABORATORY	60.00	0	22,484	10	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	20,432	10	15.00	
16.00	PHYSICAL THERAPY	66.00	0	434	10	16.00	
17.00	SPEECH PATHOLOGY	68.00	0	2,364	10	17.00	
18.00	CARDIOLOGY	76.00	0	7,579	10	18.00	
19.00	HEMATOLOGY ONCOLOGY CLINIC	90.30	0	8	10	19.00	
20.00	SLEEP DISORDERS CLINIC	90.50	0	174,297	10	20.00	
21.00	EMERGENCY	91.00	0	35,776	10	21.00	
22.00	NONPAID WORKERS	193.00	0	36,236	10	22.00	
23.00	HEALTH PROPERTIES	193.10	0	85,298	10	23.00	
24.00	WELLNESS CENTER	193.50	0	141,092	10	24.00	
			0	3,693,088			
DD - INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,998,430	0	1.00	
			0	4,998,430			
IR - INTERNS SALARY FROM LN 22 TO LN 21							
1.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	2,134,189	0	0	1.00	
			2,134,189	0			
OO - CAFETERIA FROM DIET NON-SALARIES							
1.00	DIETARY	10.00	0	1,185,016	0	1.00	
			0	1,185,016			
YY - PROPERTIES							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	263,941	14	1.00	
			0	263,941			
500.00	Grand Total: Decreases		3,363,882	129,649,306		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150058

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

Worksheet A-7
Part I
Date/Time Prepared:
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		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	21,922,667	0	0	0	0	1.00
2.00	Land Improvements	3,046,358	0	0	0	0	2.00
3.00	Buildings and Fixtures	380,272,883	14,060,808	0	14,060,808	0	3.00
4.00	Building Improvements	851,999	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	255,103,430	18,383,430	0	18,383,430	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	661,197,337	32,444,238	0	32,444,238	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	661,197,337	32,444,238	0	32,444,238	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	21,922,667	0				1.00
2.00	Land Improvements	3,046,358	0				2.00
3.00	Buildings and Fixtures	394,333,691	0				3.00
4.00	Building Improvements	851,999	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	273,486,860	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	693,641,575	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	693,641,575	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150058

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

Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150058

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

Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	395,185,690	0	395,185,690	0.591000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	273,486,860	0	273,486,860	0.409000	0	2.00
3.00	Total (sum of lines 1-2)	668,672,550	0	668,672,550	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	11,054,667	167,916	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	14,990,761	5,037,720	2.00
3.00	Total (sum of lines 1-2)	0	0	0	26,045,428	5,205,636	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,071,833	387,859	0	-2,251,639	14,430,636	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-919,053	0	0	0	19,109,428	2.00
3.00	Total (sum of lines 1-2)	4,152,780	387,859	0	-2,251,639	33,540,064	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150058

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

Worksheet A-8

Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst.	A-7 Ref.	
			3.00	4.00	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-36,853	ADMINISTRATIVE & GENERAL	5.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-1,090,602	ADMINISTRATIVE & GENERAL	5.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-14,369,311				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	1,723,654				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-1,368,248	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	B	-5,332	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines	B	-967,305	ADMINISTRATIVE & GENERAL	5.00		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		ORESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0	0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150058

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

Worksheet A-8

Date/Time Prepared:
5/29/2015 9:20 am

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	
33.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 33.00
33.01 OTHER REVENUE - MED STAFF OFFIC	B	-500	ADMINISTRATIVE & GENERAL		5.00	0 33.01
33.02 OTHER REVENUE - PEDS	B	-6,262	ADULTS & PEDIATRICS		30.00	0 33.02
33.03 OTHER REVENUE - PICU	B	100	INTENSIVE CARE UNIT		31.00	0 33.03
33.04 OTHER REVENUE - CBU	B	-2,281	DELIVERY ROOM & LABOR ROOM		52.00	0 33.04
33.05 TAXABLE SALES - FCMC	B	-3,986	ADULTS & PEDIATRICS		30.00	0 33.05
33.06 OTHER REVENUE - ER	B	-8,199	EMERGENCY		91.00	0 33.06
33.07 OTHER REVENUE - EMPLOYEE BENEFITS	B	-13,421	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.07
33.10 CONTRACTED SERVICES	B	-344,141	ADMINISTRATIVE & GENERAL		5.00	0 33.10
33.11 INTEREST INCOME - WORKING CAPIT	B	-74,345	NEW CAP REL COSTS-MVBLE EQUIP		2.00	11 33.11
33.12 OTHER REVENUE - DISTRIBUTION	B	-6,893	CENTRAL SERVICES & SUPPLY		14.00	0 33.12
33.13 OTHER REVENUE - STERILE PROCESS	B	-3,908	CENTRAL SERVICES & SUPPLY		14.00	0 33.13
33.14 OTHER REVENUE - BIOMED	B	-153,943	MAINTENANCE & REPAIRS		6.00	0 33.14
33.15 PROGRAM MEAL OFFSET	B	-127,843	DIETARY		10.00	0 33.15
33.16 VISITOR MEAL OFFSET	B	-260,540	CAFETERIA		11.00	0 33.16
33.17 OTHER REVENUE - ENGINEERING	B	-108,271	OPERATION OF PLANT		7.00	0 33.17
33.18 OTHER REVENUE - PICU TRANSPORT	B	-6,350	ADULTS & PEDIATRICS		30.00	0 33.18
33.19 OTHER REVENUE - REHAB ADMIN	B	-8,284	PHYSICAL THERAPY		66.00	0 33.19
33.22 OTHER REVENUE - RADIOLOGY DIAGN	B	-2,687	RADIOLOGY-DIAGNOSTIC		54.00	0 33.22
33.23 OTHER REVENUE - MED ED	B	-246	ADMINISTRATIVE & GENERAL		5.00	0 33.23
33.24 OTHER REVENUE - NICU	B	-375	NEONATAL INTENSIVE CARE UNIT		31.01	0 33.24
33.26 OTHER REVENUE - NEONATAL SERVICES	B	-48,392	NEONATAL INTENSIVE CARE UNIT		31.01	0 33.26
33.28 PACE CONSULTING AMORTIZATION	A	1,350	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 33.28
33.30 OTHER REVENUE - DRIVER'S ED CON	B	-17,755	OCCUPATIONAL THERAPY		67.00	0 33.30
33.31 OTHER REVENUE BCC	B	-340	RADIOLOGY-DIAGNOSTIC		54.00	0 33.31
33.35 NONALLOWABLE CAPITALIZED INTERE	A	-13,123	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 33.35
33.39 PACE COMPONENT DEPREC 29 V 23 Y	A	35,087	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 33.39
33.42 EXCESS CAPITALIZED INTEREST PAC	A	-9,762	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 33.42
33.46 ALLOWABLE CAPITALIZED INTEREST	A	10,626	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 33.46
33.48 NONALLOWABLE CAPITALIZED INTERE	A	-3,092	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 33.48
33.50 INCORRECT LIFING ON ASBESTOS AN	A	2,242	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 33.50
33.55 OTHER REVENUE - RENT	B	-2,009,042	NEW CAP REL COSTS-BLDG & FIXT		1.00	14 33.55
33.57 MEMBERSHIP REVENUE	B	-14,147	ADMINISTRATIVE & GENERAL		5.00	0 33.57
33.58 SPECIAL PROGRAM REVENUE	B	-5,992,320	ADMINISTRATIVE & GENERAL		5.00	0 33.58
33.59 SEMINAR REVENUE	B	-33,930	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.59
33.63 STERILIZATION REVENUE	B	-18,145	DELIVERY ROOM & LABOR ROOM		52.00	0 33.63
33.66 OTHER REVENUE - NUTRITIONAL SER	B	-42,739	DIETARY		10.00	0 33.66
33.71 OTHER REVENUE - SURGERY	B	-12,906	OPERATING ROOM		50.00	0 33.71
33.76 OTHER REVENUE - CATH LAB	B	-2,698	CARDIAC CATHETERIZATION		59.00	0 33.76
33.88 OTHER REVENUE - SBCSC PT	B	-225,341	PHYSICAL THERAPY		66.00	0 33.88
33.94 EDUC SERVICES EMS	B	-13,110	PARAMED ED PRGM-(SPECIFY)		23.00	0 33.94
33.96 PARKING GARAGE - OPERATING	A	-33,907	ADMINISTRATIVE & GENERAL		5.00	0 33.96
33.97 PARKING GARAGE - CAPITAL	A	-19,720	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 33.97
34.03 NON ALLOWABLE 1999 INTEREST	A	-844,708	NEW CAP REL COSTS-MVBLE EQUIP		2.00	11 34.03
34.23 ADMINISTRATION REVENUE	B	-36,565	ADMINISTRATIVE & GENERAL		5.00	0 34.23
34.31 SKYWAY INTEREST AMORTIZATION	A	3,580	NEW CAP REL COSTS-BLDG & FIXT		1.00	10 34.31
34.36 OLD CAPITAL - BUILDING	A	26,887	NEW CAP REL COSTS-BLDG & FIXT		1.00	14 34.36
34.37 NEW CAPITAL BUILDING	A	-5,543	NEW CAP REL COSTS-BLDG & FIXT		1.00	14 34.37

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		
35.02 OTHER REVENUE - AMBULANCE SUPPL	B	-69,352	CENTRAL SERVICES & SUPPLY	14.00	0	35.02
36.00 AFFILIATE RENT	B	-1,222,943	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
36.01 LOBBY EXPENSE	A	-12,063	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.05 HAF EXPENSE	A	-21,679,785	ADMINISTRATIVE & GENERAL	5.00	0	36.05
36.18 TRUSTEE FEES	A	-159,278	ADMINISTRATIVE & GENERAL	5.00	0	36.18
36.23 CONTRIBUTIONS	A	-891,699	ADMINISTRATIVE & GENERAL	5.00	0	36.23
36.25 NON-ALLOWED EXPENSES	A	-2,527	ADMINISTRATIVE & GENERAL	5.00	0	36.25
36.26 ENTRY FEES	B	-316,811	ADMINISTRATIVE & GENERAL	5.00	0	36.26
37.00 OTHER REVENUE - MATERNAL CHILD ADMIN	B	-20,576	ADULTS & PEDIATRICS	30.00	0	37.00
37.01 OTHER REVENUE - OSTC	B	-418	PHYSICAL THERAPY EAST BANK	66.01	0	37.01
37.03 OTHER REV - TRAUMA SVCS	B	-16,195	EMERGENCY	91.00	0	37.03
39.00 OTHER REVENUE - TEAM PHARMACY	B	327,287	PHARMACY	15.00	0	39.00
40.00 OTHER REVENUE - PEDS REHAB OT	B	-49,837	OCCUPATIONAL THERAPY	67.00	0	40.00
41.00 OTHER REVENUE - FCMC	B	-4,518	ADULTS & PEDIATRICS	30.00	0	41.00
42.00 OTHER REVENUE - PULMONARY MED/SURG	B	82	RESPIRATORY THERAPY	65.00	0	42.00
44.02 OTHER REVENUE - ENV SVCS	B	-400	HOUSEKEEPING	9.00	0	44.02
44.06 OTHER REVENUE - PHARMACY	B	-70,233	DRUGS CHARGED TO PATIENTS	73.00	0	44.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-50,753,151				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: 150058

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

Worksheet A-8-1

Date/Time Prepared: 5/29/2015 9:20 am

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	0.00	HOME OFFICE OLD CAP-BUILD	0	0	1.00
2.00	0.00	HOME OFFICE OLD CAP-EQUIP	0	0	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	160,728	0	3.00
4.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	1,344,632	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	24,796,649	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	0	24,578,355	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		26,302,009	24,578,355	5.00

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

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

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

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

6.00	B	0.00	BEACON HLTH SYS	100.00	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:				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: 150058

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2015 9:20 am

	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	0	0		1.00
2.00	0	0		2.00
3.00	160,728	10		3.00
4.00	1,344,632	10		4.00
4.01	24,796,649	0		4.01
4.02	-24,578,355	0		4.02
5.00	1,723,654			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	HOME OFFICE		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: 150058

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2015 9:20 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	DR. A	2,850	0	2,850	171,400	3	1.00
2.00	5.00	DR. F	120,169	0	120,169	171,400	1,008	2.00
3.00	5.00	DR. H	9,195	0	9,195	171,400	61	3.00
4.00	5.00	DR. M	150	0	150	171,400	2	4.00
5.00	5.00	DR. AN	171,675	0	171,675	142,500	938	5.00
6.00	5.00	DR. N	2,295	0	2,295	171,400	2	6.00
7.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	2,848,922	2,848,922	0	0	0	7.00
8.00	5.00	DR. S	3,038	0	3,038	171,400	20	8.00
9.00	5.00	DR. W	41,563	0	41,563	171,400	331	9.00
10.00	16.00	DR. I	5,563	0	5,563	171,400	3	10.00
11.00	16.00	DR. AS	14,475	0	14,475	171,400	97	11.00
12.00	31.01	DR. L	54,618	54,618	0	0	0	12.00
13.00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	1,425	1,425	0	0	0	13.00
14.00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	23,550	0	23,550	152,100	157	14.00
15.00	50.00	DR. C	28,650	0	28,650	204,100	191	15.00
16.00	50.00	DR. AH	31,792	0	31,792	204,100	204	16.00
17.00	50.00	DR. AS	3,315	0	3,315	204,100	20	17.00
18.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	1,469,450	1,469,450	0	0	0	18.00
19.00	54.00	DR. D	1,700	0	1,700	231,000	9	19.00
20.00	54.00	DR. F	51,942	0	51,942	231,000	336	20.00
21.00	54.00	DR. J	9,375	0	9,375	231,100	59	21.00
22.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	85,000	85,000	0	0	0	22.00
23.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	48,000	0	48,000	231,000	240	23.00
24.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	1,200	0	1,200	231,000	6	24.00
25.00	54.00	DR. T	4,785	0	4,785	231,000	32	25.00
26.00	59.00	DR. M	3,000	0	3,000	231,000	2	26.00
27.00	60.00	AGGREGATE-LABORATORY	137,500	0	137,500	219,500	3,192	27.00
28.00	66.00	DR. AC	8,338	0	8,338	171,400	21	28.00
29.00	66.00	DR. AL	30,600	0	30,600	171,400	124	29.00
30.00	76.00	DR. AA	20,325	0	20,325	171,400	32	30.00
31.00	76.00	DR. AP	5,370	0	5,370	171,400	9	31.00
32.00	76.00	AGGREGATE-CARDIOLOGY	4,000	4,000	0	0	0	32.00
33.00	76.00	AGGREGATE-CARDIOLOGY	29,063	29,063	0	0	0	33.00
34.00	90.50	DR. BA	14,850	0	14,850	171,400	99	34.00
35.00	91.00	DR. BB	100,001	0	100,001	171,400	647	35.00
36.00	91.00	AGGREGATE-EMERGENCY	2,012,882	2,012,882	0	0	0	36.00
37.00	91.00	AGGREGATE-EMERGENCY	7,050,131	7,050,131	0	0	0	37.00
38.00	91.00	DR. R	8,563	0	8,563	171,400	69	38.00
39.00	91.00	DR. BS	356,200	0	356,200	171,400	2,091	39.00
40.00	91.00	DR. BT	434,164	0	434,164	171,400	2,061	40.00
200.00			15,249,684	13,555,491	1,694,193		12,066	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	DR. A	247	12	0	0	0	1.00
2.00	5.00	DR. F	83,063	4,153	0	0	0	2.00
3.00	5.00	DR. H	5,027	251	0	0	0	3.00
4.00	5.00	DR. M	165	8	0	0	0	4.00
5.00	5.00	DR. AN	64,262	3,213	0	0	0	5.00
6.00	5.00	DR. N	165	8	0	0	0	6.00
7.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	7.00
8.00	5.00	DR. S	1,648	82	0	0	0	8.00
9.00	5.00	DR. W	27,276	1,364	0	0	0	9.00
10.00	16.00	DR. I	247	12	0	0	0	10.00
11.00	16.00	DR. AS	7,993	400	0	0	0	11.00
12.00	31.01	DR. L	0	0	0	0	0	12.00
13.00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	0	0	13.00
14.00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	11,481	574	0	0	0	14.00
15.00	50.00	DR. C	18,742	937	0	0	0	15.00
16.00	50.00	DR. AH	20,018	1,001	0	0	0	16.00
17.00	50.00	DR. AS	1,962	98	0	0	0	17.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150058

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2015 9:20 am

	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	
18.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	18.00
19.00	54.00	DR. D	1,000	50	0	0	0	19.00
20.00	54.00	DR. F	37,315	1,866	0	0	0	20.00
21.00	54.00	DR. J	6,555	328	0	0	0	21.00
22.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	22.00
23.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	26,654	1,333	0	0	0	23.00
24.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	666	33	0	0	0	24.00
25.00	54.00	DR. T	3,554	178	0	0	0	25.00
26.00	59.00	DR. M	222	11	0	0	0	26.00
27.00	60.00	AGGREGATE-LABORATORY	336,848	16,842	0	0	0	27.00
28.00	66.00	DR. AC	1,730	87	0	0	0	28.00
29.00	66.00	DR. AL	10,218	511	0	0	0	29.00
30.00	76.00	DR. AA	2,637	132	0	0	0	30.00
31.00	76.00	DR. AP	742	37	0	0	0	31.00
32.00	76.00	AGGREGATE-CARDIOLOGY	0	0	0	0	0	32.00
33.00	76.00	AGGREGATE-CARDIOLOGY	0	0	0	0	0	33.00
34.00	90.50	DR. BA	8,158	408	0	0	0	34.00
35.00	91.00	DR. BB	53,315	2,666	0	0	0	35.00
36.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	36.00
37.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	37.00
38.00	91.00	DR. R	5,686	284	0	0	0	38.00
39.00	91.00	DR. BS	172,306	8,615	0	0	0	39.00
40.00	91.00	DR. BT	169,834	8,492	0	0	0	40.00
200.00			1,079,736	53,986	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	DR. A	0	247	2,603	2,603		1.00
2.00	5.00	DR. F	0	83,063	37,106	37,106		2.00
3.00	5.00	DR. H	0	5,027	4,168	4,168		3.00
4.00	5.00	DR. M	0	165	0	0		4.00
5.00	5.00	DR. AN	0	64,262	107,413	107,413		5.00
6.00	5.00	DR. N	0	165	2,130	2,130		6.00
7.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	2,848,922		7.00
8.00	5.00	DR. S	0	1,648	1,390	1,390		8.00
9.00	5.00	DR. W	0	27,276	14,287	14,287		9.00
10.00	16.00	DR. I	0	247	5,316	5,316		10.00
11.00	16.00	DR. AS	0	7,993	6,482	6,482		11.00
12.00	31.01	DR. L	0	0	0	54,618		12.00
13.00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	0	0	1,425		13.00
14.00	31.01	AGGREGATE-NEONATAL INTENSIVE CARE UN	0	11,481	12,069	12,069		14.00
15.00	50.00	DR. C	0	18,742	9,908	9,908		15.00
16.00	50.00	DR. AH	0	20,018	11,774	11,774		16.00
17.00	50.00	DR. AS	0	1,962	1,353	1,353		17.00
18.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	1,469,450		18.00
19.00	54.00	DR. D	0	1,000	700	700		19.00
20.00	54.00	DR. F	0	37,315	14,627	14,627		20.00
21.00	54.00	DR. J	0	6,555	2,820	2,820		21.00
22.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	85,000		22.00
23.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	26,654	21,346	21,346		23.00
24.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	666	534	534		24.00
25.00	54.00	DR. T	0	3,554	1,231	1,231		25.00
26.00	59.00	DR. M	0	222	2,778	2,778		26.00
27.00	60.00	AGGREGATE-LABORATORY	0	336,848	0	0		27.00
28.00	66.00	DR. AC	0	1,730	6,608	6,608		28.00
29.00	66.00	DR. AL	0	10,218	20,382	20,382		29.00
30.00	76.00	DR. AA	0	2,637	17,688	17,688		30.00
31.00	76.00	DR. AP	0	742	4,628	4,628		31.00
32.00	76.00	AGGREGATE-CARDIOLOGY	0	0	0	4,000		32.00
33.00	76.00	AGGREGATE-CARDIOLOGY	0	0	0	29,063		33.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150058

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

Worksheet A-8-2

Date/Time Prepared:
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	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		
34.00	90.50	DR. BA	0	8,158	6,692	6,692		34.00
35.00	91.00	DR. BB	0	53,315	46,686	46,686		35.00
36.00	91.00	AGGREGATE-EMERGENCY	0	0	0	2,012,882		36.00
37.00	91.00	AGGREGATE-EMERGENCY	0	0	0	7,050,131		37.00
38.00	91.00	DR. R	0	5,686	2,877	2,877		38.00
39.00	91.00	DR. BS	0	172,306	183,894	183,894		39.00
40.00	91.00	DR. BT	0	169,834	264,330	264,330		40.00
200.00			0	1,079,736	813,820	14,369,311		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150058

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	14,430,636	14,430,636			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	19,109,428		19,109,428		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,221,360	120,824	159,999	2,502,183	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	41,799,833	1,140,808	1,510,688	135,146	44,586,475
6.00 00600	MAINTENANCE & REPAIRS	4,760,810	42,456	56,221	10,710	4,870,197
7.00 00700	OPERATION OF PLANT	8,268,108	2,256,264	2,987,804	49,259	13,561,435
8.00 00800	LAUNDRY & LINEN SERVICE	1,678,658	1,878	2,487	0	1,683,023
9.00 00900	HOUSEKEEPING	5,166,656	258,156	341,856	57,440	5,824,108
10.00 01000	DIETARY	3,209,500	286,779	379,760	31,917	3,907,956
11.00 01100	CAFETERIA	785,921	55,816	73,913	22,797	938,447
13.00 01300	NURSING ADMINISTRATION	1,855,156	220,414	291,878	23,584	2,391,032
14.00 01400	CENTRAL SERVICES & SUPPLY	6,180,863	373,233	494,245	35,825	7,084,166
15.00 01500	PHARMACY	13,350,703	122,578	162,321	107,643	13,743,245
16.00 01600	MEDICAL RECORDS & LIBRARY	3,579,790	68,056	90,122	41,598	3,779,566
17.00 01700	SOCIAL SERVICE	3,847,808	43,650	57,802	51,459	4,000,719
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,134,189	0	0	39,566	2,173,755
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,792,163	198,832	263,298	44,351	5,298,644
23.00 02300	PARAMED ED PRGM-(SPECIFY)	130,932	47,780	63,271	1,667	243,650
23.01 02301	PARAMED ED	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	42,424,137	2,769,451	3,667,385	550,987	49,411,960
31.00 03100	INTENSIVE CARE UNIT	8,259,083	210,898	279,277	97,173	8,846,431
31.01 02060	NEONATAL INTENSIVE CARE UNIT	6,938,589	105,984	140,347	93,442	7,278,362
40.00 04000	SUBPROVIDER - I PF	2,288,657	155,244	205,578	27,768	2,677,247
41.00 04100	SUBPROVIDER - I RF	1,924,885	146,226	193,636	26,278	2,291,025
43.00 04300	NURSERY	1,579,297	57,520	76,169	22,611	1,735,597
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	22,440,106	1,228,730	1,627,116	239,188	25,535,140
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,006,076	449,387	595,090	77,728	7,128,281
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,709,256	734,051	972,049	159,502	15,574,858
57.00 05700	CT SCAN	1,728,879	35,913	47,556	21,848	1,834,196
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	603,612	54,049	71,574	0	729,235
59.00 05900	CARDIAC CATHETERIZATION	2,073,872	214,468	284,004	20,971	2,593,315
60.00 06000	LABORATORY	12,561,611	139,384	184,576	47,170	12,932,741
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	4,146,649	127,019	168,202	52,698	4,494,568
66.00 06600	PHYSICAL THERAPY	3,407,182	148,141	196,172	50,159	3,801,654
66.01 06602	PHYSICAL THERAPY EAST BANK	1,342,829	0	0	18,905	1,361,734
66.10 06601	PHYSICAL THERAPY LIVING CENTER	385,063	0	0	5,843	390,906
67.00 06700	OCCUPATIONAL THERAPY	1,746,713	96,891	128,305	26,901	1,998,810
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	250,522	0	0	3,635	254,157
68.00 06800	SPEECH PATHOLOGY	1,026,948	4,329	5,732	15,127	1,052,136
68.10 06801	SPEECH THERAPY LIVING CENTER	192,225	0	0	2,944	195,169
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,896,815	0	0	0	9,896,815
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	32,893,878	0	0	0	32,893,878
73.00 07300	DRUGS CHARGED TO PATIENTS	14,871,418	0	0	0	14,871,418
76.00 03020	CARDIOLOGY	2,966,657	92,450	122,425	20,237	3,201,769
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	914,550	116,446	154,200	12,986	1,198,182
90.50 09004	SLEEP DISORDERS CLINIC	828,315	0	0	10,716	839,031
91.00 09100	EMERGENCY	14,498,502	434,223	575,010	174,405	15,682,140
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	349,208,840	12,558,328	16,630,068	2,432,184	344,787,173
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59,224	78,426	0	137,650
193.00 19300	NONPAID WORKERS	1,618,478	1,725,934	2,285,527	13,727	5,643,666
193.10 19301	HEALTH PROPERTIES	4,452,744	0	0	33,425	4,486,169
193.40 19303	LEIGHTON CENTER	0	78,393	103,810	0	182,203
193.50 19305	WELLNESS CENTER	1,568,240	0	0	17,540	1,585,780
193.80 19308	UNUSED SPACE	0	0	0	0	0
193.90 19309	OCCUPATIONAL HEALTH	0	0	0	0	0
193.91 19310	RESEARCH AND PROTOCOL	0	0	0	0	0
193.92 19311	CCOP	165	3,396	4,497	0	8,058

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150058

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
193.93 19312 RESEARCH ADMIN	366,725	5,361	7,100	5,307	384,493	193.93
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)	357,215,192	14,430,636	19,109,428	2,502,183	357,215,192	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared: 5/29/2015 9:20 am
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,586,475				5.00
6.00	00600	MAINTENANCE & REPAIRS	694,578	5,564,775			6.00
7.00	00700	OPERATION OF PLANT	1,934,105	956,505	16,452,045		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	240,029	796	2,843	1,926,691	8.00
9.00	00900	HOUSEKEEPING	830,623	109,441	390,715	0	7,154,887
10.00	01000	DIETARY	557,345	121,575	434,036	0	9,341
11.00	01100	CAFETERIA	133,839	23,662	84,476	0	0
13.00	01300	NURSING ADMINISTRATION	341,004	93,441	333,594	0	32,068
14.00	01400	CENTRAL SERVICES & SUPPLY	1,010,330	158,226	564,883	19,065	119,520
15.00	01500	PHARMACY	1,960,034	51,965	185,521	0	400,632
16.00	01600	MEDICAL RECORDS & LIBRARY	539,034	28,851	103,002	0	9,120
17.00	01700	SOCIAL SERVICE	570,575	18,505	66,064	0	118,196
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	310,017	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	755,682	84,291	300,930	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	34,749	20,255	72,314	0	0
23.01	02301	PARAMED ED	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,047,030	1,174,060	4,191,533	668,097	2,786,550
31.00	03100	INTENSIVE CARE UNIT	1,261,660	89,407	319,192	53,625	247,352
31.01	02060	NEONATAL INTENSIVE CARE UNIT	1,038,025	44,930	160,405	59,730	115,622
40.00	04000	SUBPROVIDER - IPF	381,824	65,813	234,960	32,149	20,815
41.00	04100	SUBPROVIDER - IRF	326,741	61,990	221,311	71,187	275,963
43.00	04300	NURSERY	247,527	24,385	87,056	17,844	159,017
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,641,771	520,899	1,859,668	255,635	331,053
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,016,621	190,510	680,142	88,468	276,184
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,221,255	311,188	1,110,977	184,020	580,832
57.00	05700	CT SCAN	261,589	15,225	54,353	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	104,002	22,913	81,803	7,419	0
59.00	05900	CARDIAC CATHETERIZATION	369,853	90,920	324,595	73,911	95,322
60.00	06000	LABORATORY	1,844,442	59,089	210,956	0	191,453
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	641,006	53,848	192,242	0	0
66.00	06600	PHYSICAL THERAPY	542,184	62,802	224,210	34,460	85,981
66.01	06602	PHYSICAL THERAPY EAST BANK	194,208	0	0	0	0
66.10	06601	PHYSICAL THERAPY LIVING CENTER	55,750	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	285,066	41,075	146,643	0	4,045
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	36,247	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	150,054	1,835	6,552	0	25,007
68.10	06801	SPEECH THERAPY LIVING CENTER	27,835	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,411,464	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,691,259	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,120,932	0	0	0	0
76.00	03020	CARDIOLOGY	456,630	39,193	139,922	0	10,371
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	170,882	49,365	176,239	30,616	93,704
90.50	09004	SLEEP DISORDERS CLINIC	119,661	0	0	12,319	0
91.00	09100	EMERGENCY	2,236,555	184,082	657,192	134,673	152,986
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,814,017	4,771,042	13,618,329	1,743,218	6,141,134
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,631	25,107	89,635	0	0
193.00	19300	NONPAID WORKERS	804,888	731,680	2,612,180	0	1,007,795
193.10	19301	HEALTH PROPERTIES	639,808	0	0	0	0
193.40	19303	LEIGHTON CENTER	25,985	33,233	118,647	0	5,958
193.50	19305	WELLNESS CENTER	226,161	0	0	183,473	0
193.80	19308	UNUSED SPACE	0	0	0	0	0
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0
193.92	19311	CCOP	1,149	1,440	5,140	0	0
193.93	19312	RESEARCH ADMIN	54,836	2,273	8,114	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	44,586,475	5,564,775	16,452,045	1,926,691	7,154,887

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150058

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

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	5,030,253					10.00
11.00	01100	0	1,180,424				11.00
13.00	01300	0	11,250	3,202,389			13.00
14.00	01400	0	27,435	43	8,983,668		14.00
15.00	01500	0	42,811	0	0	16,384,208	15.00
16.00	01600	0	28,589	17,091	0	0	16.00
17.00	01700	0	29,324	11,818	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	29,922	0	0	0	22.00
23.00	02300	0	1,016	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,147,303	340,417	1,405,043	0	6,806	30.00
31.00	03100	385,417	50,524	273,620	0	296	31.00
31.01	02060	0	39,765	213,337	0	1,728	31.01
40.00	04000	269,802	20,593	57,154	0	0	40.00
41.00	04100	227,731	14,134	59,589	0	292	41.00
43.00	04300	0	11,800	51,203	0	37	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	117,561	433,374	0	3,469	50.00
52.00	05200	0	40,514	193,565	0	21	52.00
54.00	05400	0	81,481	79,795	0	5,334	54.00
57.00	05700	0	9,881	0	0	16	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	10,041	25,858	0	873	59.00
60.00	06000	0	35,503	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	0	26,825	0	0	3,623	65.00
66.00	06600	0	21,655	0	0	723	66.00
66.01	06602	0	10,237	0	0	0	66.01
66.10	06601	0	2,326	0	0	0	66.10
67.00	06700	0	12,257	0	0	0	67.00
67.10	06701	0	1,853	0	0	26	67.10
68.00	06800	0	6,589	0	0	0	68.00
68.10	06801	0	1,115	0	0	0	68.10
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	8,983,668	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	16,340,640	73.00
76.00	03020	0	8,179	18,911	0	706	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.10	09001	0	0	0	0	0	90.10
90.30	09002	0	5,653	29,502	0	168	90.30
90.50	09004	0	5,504	0	0	0	90.50
91.00	09100	0	82,954	303,724	0	13,997	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		5,030,253	1,127,708	3,173,627	8,983,668	16,378,755	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
193.00	19300	0	12,057	3,942	0	4,200	193.00
193.10	19301	0	24,576	18,338	0	1,120	193.10
193.40	19303	0	0	0	0	0	193.40
193.50	19305	0	13,360	0	0	0	193.50
193.80	19308	0	0	0	0	0	193.80
193.90	19309	0	0	0	0	0	193.90
193.91	19310	0	136	182	0	0	193.91
193.92	19311	0	0	0	0	133	193.92
193.93	19312	0	2,587	6,300	0	0	193.93
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		5,030,253	1,180,424	3,202,389	8,983,668	16,384,208	202.00

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	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	4,505,253					16.00
17.00 01700 SOCIAL SERVICE	0	4,815,201				17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,483,772			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	6,469,469		22.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0	0	0	371,984	23.00
23.01 02301 PARAMED PRGM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	737,018	2,971,946	1,977,427	5,150,600		30.00
31.00 03100 INTENSIVE CARE UNIT	56,369	284,616	0	0		31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	19,729	167,358	19,880	51,780		31.01
40.00 04000 SUBPROVIDER - IPF	39,458	285,113	0	0		40.00
41.00 04100 SUBPROVIDER - IRF	18,320	148,560	0	0		41.00
43.00 04300 NURSERY	14,092	0	0	0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,034,362	1,159	155,528	405,103		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	11,925	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	777,885	0	31,573	82,239		54.00
57.00 05700 CT SCAN	0	0	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00 06000 LABORATORY	349,485	0	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0	63,147	164,478		65.00
66.00 06600 PHYSICAL THERAPY	486,178	0	0	0		66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	0		66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0		66.10
67.00 06700 OCCUPATIONAL THERAPY	119,783	0	0	0		67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0		67.10
68.00 06800 SPEECH PATHOLOGY	56,369	0	0	0		68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	0		68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
76.00 03020 RADIOLOGY	326,937	0	68,994	179,707		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0		90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	0		90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	79,331	4,678	12,184		90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	0		90.50
91.00 09100 EMERGENCY	469,268	716,550	145,004	377,690	371,984	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0	0	0	0		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	4,505,253	4,666,558	2,466,231	6,423,781	371,984	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
193.00 19300 NONPAID WORKERS	0	0	17,541	45,688		193.00
193.10 19301 HEALTH PROPERTIES	0	0	0	0		193.10
193.40 19303 LEIGHTON CENTER	0	0	0	0		193.40
193.50 19305 WELLNESS CENTER	0	0	0	0		193.50
193.80 19308 UNUSED SPACE	0	0	0	0		193.80
193.90 19309 OCCUPATIONAL HEALTH	0	148,643	0	0		193.90
193.91 19310 RESEARCH AND PROTOCOL	0	0	0	0		193.91
193.92 19311 CCOP	0	0	0	0		193.92
193.93 19312 RESEARCH ADMIN	0	0	0	0		193.93
200.00 Cross Foot Adjustments	0	0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150058

Period:
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
	16.00	17.00	21.00	22.00	23.00	
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	4,505,253	4,815,201	2,483,772	6,469,469	371,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150058

Period:
From 01/01/2014
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Cost Center Description			PARAMED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.01	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	PARAMED PRGM-(SPECIFY)					23.00
23.01	02301	PARAMED ED	0				23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	82,015,790	-7,128,027	74,887,763	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,868,509	0	11,868,509	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	9,210,651	-71,660	9,138,991	31.01
40.00	04000	SUBPROVIDER - IPF	0	4,084,928	0	4,084,928	40.00
41.00	04100	SUBPROVIDER - IRF	0	3,716,843	0	3,716,843	41.00
43.00	04300	NURSERY	0	2,348,558	0	2,348,558	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	34,294,722	-560,631	33,734,091	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,626,231	0	9,626,231	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,041,437	-113,812	20,927,625	54.00
57.00	05700	CT SCAN	0	2,175,260	0	2,175,260	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	945,372	0	945,372	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,584,688	0	3,584,688	59.00
60.00	06000	LABORATORY	0	15,623,669	0	15,623,669	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	5,639,737	-227,625	5,412,112	65.00
66.00	06600	PHYSICAL THERAPY	0	5,259,847	0	5,259,847	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	1,566,179	0	1,566,179	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	448,982	0	448,982	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	2,607,679	0	2,607,679	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	292,283	0	292,283	67.10
68.00	06800	SPEECH PATHOLOGY	0	1,298,542	0	1,298,542	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	224,119	0	224,119	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,291,947	0	20,291,947	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	37,585,137	0	37,585,137	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	33,332,990	0	33,332,990	73.00
76.00	03020	CARDIOLOGY	0	4,451,319	-248,701	4,202,618	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	1,850,504	-16,862	1,833,642	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	976,515	0	976,515	90.50
91.00	09100	EMERGENCY	0	21,528,799	-522,694	21,006,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	337,891,237	-8,890,012	329,001,225	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	272,023	0	272,023	190.00
193.00	19300	NONPAID WORKERS	0	10,883,637	-63,229	10,820,408	193.00
193.10	19301	HEALTH PROPERTIES	0	5,170,011	0	5,170,011	193.10
193.40	19303	LEIGHTON CENTER	0	366,026	0	366,026	193.40
193.50	19305	WELLNESS CENTER	0	2,008,774	0	2,008,774	193.50
193.80	19308	UNUSED SPACE	0	0	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	148,643	0	148,643	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	318	0	318	193.91
193.92	19311	CCOP	0	15,920	0	15,920	193.92
193.93	19312	RESEARCH ADMIN	0	458,603	0	458,603	193.93
200.00		Cross Foot Adjustments	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		PARAMED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.01	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	357,215,192	-8,953,241	348,261,951		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150058

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	120,824	159,999	280,823	280,823
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,140,808	1,510,688	2,651,496	15,170
6.00 00600	MAINTENANCE & REPAIRS	0	42,456	56,221	98,677	1,202
7.00 00700	OPERATION OF PLANT	0	2,256,264	2,987,804	5,244,068	5,529
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,878	2,487	4,365	0
9.00 00900	HOUSEKEEPING	0	258,156	341,856	600,012	6,448
10.00 01000	DIETARY	0	286,779	379,760	666,539	3,583
11.00 01100	CAFETERIA	0	55,816	73,913	129,729	2,559
13.00 01300	NURSING ADMINISTRATION	0	220,414	291,878	512,292	2,647
14.00 01400	CENTRAL SERVICES & SUPPLY	0	373,233	494,245	867,478	4,021
15.00 01500	PHARMACY	0	122,578	162,321	284,899	12,083
16.00 01600	MEDICAL RECORDS & LIBRARY	0	68,056	90,122	158,178	4,669
17.00 01700	SOCIAL SERVICE	0	43,650	57,802	101,452	5,776
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	4,441
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	198,832	263,298	462,130	4,978
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	47,780	63,271	111,051	187
23.01 02301	PARAMED ED	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	2,769,451	3,667,385	6,436,836	61,802
31.00 03100	INTENSIVE CARE UNIT	0	210,898	279,277	490,175	10,908
31.01 02060	NEONATAL INTENSIVE CARE UNIT	0	105,984	140,347	246,331	10,489
40.00 04000	SUBPROVIDER - IPF	0	155,244	205,578	360,822	3,117
41.00 04100	SUBPROVIDER - IRF	0	146,226	193,636	339,862	2,950
43.00 04300	NURSERY	0	57,520	76,169	133,689	2,538
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	1,228,730	1,627,116	2,855,846	26,849
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	449,387	595,090	1,044,477	8,725
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	734,051	972,049	1,706,100	17,904
57.00 05700	CT SCAN	0	35,913	47,556	83,469	2,452
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	54,049	71,574	125,623	0
59.00 05900	CARDIAC CATHETERIZATION	0	214,468	284,004	498,472	2,354
60.00 06000	LABORATORY	0	139,384	184,576	323,960	5,295
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	127,019	168,202	295,221	5,915
66.00 06600	PHYSICAL THERAPY	0	148,141	196,172	344,313	5,630
66.01 06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	2,122
66.10 06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	656
67.00 06700	OCCUPATIONAL THERAPY	0	96,891	128,305	225,196	3,020
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	408
68.00 06800	SPEECH PATHOLOGY	0	4,329	5,732	10,061	1,698
68.10 06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	330
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	CARDIOLOGY	0	92,450	122,425	214,875	2,272
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	0	116,446	154,200	270,646	1,458
90.50 09004	SLEEP DISORDERS CLINIC	0	0	0	0	1,203
91.00 09100	EMERGENCY	0	434,223	575,010	1,009,233	19,577
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	12,558,328	16,630,068	29,188,396	272,965
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59,224	78,426	137,650	0
193.00 19300	NONPAID WORKERS	0	1,725,934	2,285,527	4,011,461	1,541
193.10 19301	HEALTH PROPERTIES	0	0	0	0	3,752
193.40 19303	LEIGHTON CENTER	0	78,393	103,810	182,203	0
193.50 19305	WELLNESS CENTER	0	0	0	0	1,969
193.80 19308	UNUSED SPACE	0	0	0	0	0
193.90 19309	OCCUPATIONAL HEALTH	0	0	0	0	0
193.91 19310	RESEARCH AND PROTOCOL	0	0	0	0	0
193.92 19311	CCOP	0	3,396	4,497	7,893	0
193.93 19312	RESEARCH ADMIN	0	5,361	7,100	12,461	596

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150058

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
200.00	Cross Foot Adjustments			0		200.00
201.00	Negative Cost Centers			0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	14,430,636	19,109,428	33,540,064	280,823

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/29/2015 9:20 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	2,666,666			5.00		
6.00	00600	MAINTENANCE & REPAIRS	41,543	141,422		6.00		
7.00	00700	OPERATION OF PLANT	115,679	24,308	5,389,584	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	14,356	20	931	19,672	8.00	
9.00	00900	HOUSEKEEPING	49,680	2,781	127,996	0	786,917	9.00
10.00	01000	DIETARY	33,335	3,090	142,187	0	1,027	10.00
11.00	01100	CAFETERIA	8,005	601	27,674	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	20,396	2,375	109,283	0	3,527	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,428	4,021	185,052	195	13,145	14.00
15.00	01500	PHARMACY	117,230	1,321	60,775	0	44,063	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,240	733	33,743	0	1,003	16.00
17.00	01700	SOCIAL SERVICE	34,126	470	21,642	0	13,000	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	18,542	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	45,197	2,142	98,583	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	2,078	515	23,690	0	0	23.00
23.01	02301	PARAMED ED	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	421,426	29,836	1,373,121	6,821	306,474	30.00
31.00	03100	INTENSIVE CARE UNIT	75,460	2,272	104,565	547	27,205	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	62,084	1,142	52,548	610	12,716	31.01
40.00	04000	SUBPROVIDER - IPF	22,837	1,673	76,971	328	2,289	40.00
41.00	04100	SUBPROVIDER - IRF	19,542	1,575	72,500	727	30,351	41.00
43.00	04300	NURSERY	14,805	620	28,519	182	17,489	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	217,815	13,238	609,215	2,610	36,410	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	60,804	4,842	222,810	903	30,376	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	132,854	7,908	363,949	1,879	63,882	54.00
57.00	05700	CT SCAN	15,646	387	17,806	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,220	582	26,798	76	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,121	2,311	106,335	755	10,484	59.00
60.00	06000	LABORATORY	110,316	1,502	69,108	0	21,057	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	38,339	1,368	62,977	0	0	65.00
66.00	06600	PHYSICAL THERAPY	32,428	1,596	73,450	352	9,456	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	11,616	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	3,334	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	17,050	1,044	48,039	0	445	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	2,168	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	8,975	47	2,146	0	2,750	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	1,665	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,420	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	280,585	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	126,853	0	0	0	0	73.00
76.00	03020	CARDIOLOGY	27,311	996	45,837	0	1,141	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	10,220	1,255	57,735	313	10,306	90.30
90.50	09004	SLEEP DISORDERS CLINIC	7,157	0	0	126	0	90.50
91.00	09100	EMERGENCY	133,769	4,678	215,292	1,375	16,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,560,655	121,249	4,461,277	17,799	675,422	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,174	638	29,364	0	0	190.00
193.00	19300	NONPAID WORKERS	48,140	18,595	855,733	0	110,840	193.00
193.10	19301	HEALTH PROPERTIES	38,267	0	0	0	0	193.10
193.40	19303	LEIGHTON CENTER	1,554	845	38,868	0	655	193.40
193.50	19305	WELLNESS CENTER	13,527	0	0	1,873	0	193.50
193.80	19308	UNUSED SPACE	0	0	0	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92	19311	CCOP	69	37	1,684	0	0	193.92
193.93	19312	RESEARCH ADMIN	3,280	58	2,658	0	0	193.93
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)	2,666,666	141,422	5,389,584	19,672	786,917	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150058		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/29/2015 9:20 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	849,761					10.00
11.00	01100	CAFETERIA	0	168,568				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,607	652,127			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,918	9	1,138,267		14.00
15.00	01500	PHARMACY	0	6,114	0	0	526,485	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,083	3,480	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,188	2,407	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	4,273	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	145	0	0	0	23.00
23.01	02301	PARAMED ED	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	700,604	48,610	286,120	0	219	30.00
31.00	03100	INTENSIVE CARE UNIT	65,108	7,215	55,719	0	10	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	5,679	43,443	0	56	31.01
40.00	04000	SUBPROVIDER - I/PF	45,578	2,941	11,639	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	38,471	2,018	12,134	0	9	41.00
43.00	04300	NURSERY	0	1,685	10,427	0	1	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	16,788	88,251	0	111	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,786	39,417	0	1	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,636	16,249	0	171	54.00
57.00	05700	CT SCAN	0	1,411	0	0	1	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,434	5,266	0	28	59.00
60.00	06000	LABORATORY	0	5,070	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	3,831	0	0	116	65.00
66.00	06600	PHYSICAL THERAPY	0	3,092	0	0	23	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	1,462	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	332	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	1,750	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	265	0	0	1	67.10
68.00	06800	SPEECH PATHOLOGY	0	941	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	159	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,138,267	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	525,085	73.00
76.00	03020	CARDIOLOGY	0	1,168	3,851	0	23	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	807	6,008	0	5	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	786	0	0	0	90.50
91.00	09100	EMERGENCY	0	11,846	61,850	0	450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	849,761	161,040	646,270	1,138,267	526,310	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
193.00	19300	NONPAID WORKERS	0	1,722	803	0	135	193.00
193.10	19301	HEALTH PROPERTIES	0	3,510	3,734	0	36	193.10
193.40	19303	LEIGHTON CENTER	0	0	0	0	0	193.40
193.50	19305	WELLNESS CENTER	0	1,908	0	0	0	193.50
193.80	19308	UNUSED SPACE	0	0	0	0	0	193.80
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0	193.90
193.91	19310	RESEARCH AND PROTOCOL	0	19	37	0	0	193.91
193.92	19311	CCOP	0	0	0	0	4	193.92
193.93	19312	RESEARCH ADMIN	0	369	1,283	0	0	193.93
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	849,761	168,568	652,127	1,138,267	526,485	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150058

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	238,129					16.00
17.00 01700 SOCIAL SERVICE	0	183,061				17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	22,983			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	617,303		22.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0	0	0	137,666	23.00
23.01 02301 PARAMED PRGM	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	38,956	112,987				30.00
31.00 03100 INTENSIVE CARE UNIT	2,979	10,820				31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	1,043	6,362				31.01
40.00 04000 SUBPROVIDER - IPF	2,086	10,839				40.00
41.00 04100 SUBPROVIDER - IRF	968	5,648				41.00
43.00 04300 NURSERY	745	0				43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	54,672	44				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	453				52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	41,116	0				54.00
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	18,472	0				60.00
60.01 06001 BLOOD LABORATORY	0	0				60.01
65.00 06500 RESPIRATORY THERAPY	0	0				65.00
66.00 06600 PHYSICAL THERAPY	25,697	0				66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0				66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0				66.10
67.00 06700 OCCUPATIONAL THERAPY	6,331	0				67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0				67.10
68.00 06800 SPEECH PATHOLOGY	2,979	0				68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0				68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76.00 03020 RADIOLOGY	17,281	0				76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0				90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0				90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	3,016				90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0				90.50
91.00 09100 EMERGENCY	24,804	27,241				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0	0				113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	238,129	177,410	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
193.00 19300 NONPAID WORKERS	0	0				193.00
193.10 19301 HEALTH PROPERTIES	0	0				193.10
193.40 19303 LEIGHTON CENTER	0	0				193.40
193.50 19305 WELLNESS CENTER	0	0				193.50
193.80 19308 UNUSED SPACE	0	0				193.80
193.90 19309 OCCUPATIONAL HEALTH	0	5,651				193.90
193.91 19310 RESEARCH AND PROTOCOL	0	0				193.91
193.92 19311 CCOP	0	0				193.92
193.93 19312 RESEARCH ADMIN	0	0				193.93
200.00 Cross Foot Adjustments			22,983	617,303	137,666	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150058

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

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	238,129	183,061	22,983	617,303	137,666	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/29/2015 9:20 am	
Cost Center Description	PARAMED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23.01	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00 02300	PARAMED PRGM-(SPECIFY)				23.00
23.01 02301	PARAMED ED	0			23.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	9,823,812	0	9,823,812	30.00
31.00 03100	INTENSIVE CARE UNIT	852,983	0	852,983	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	442,503	0	442,503	31.01
40.00 04000	SUBPROVIDER - IPF	541,120	0	541,120	40.00
41.00 04100	SUBPROVIDER - IRF	526,755	0	526,755	41.00
43.00 04300	NURSERY	210,700	0	210,700	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	3,921,849	0	3,921,849	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,418,594	0	1,418,594	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,363,648	0	2,363,648	54.00
57.00 05700	CT SCAN	121,172	0	121,172	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	159,299	0	159,299	58.00
59.00 05900	CARDIAC CATHETERIZATION	649,560	0	649,560	59.00
60.00 06000	LABORATORY	554,780	0	554,780	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	407,767	0	407,767	65.00
66.00 06600	PHYSICAL THERAPY	496,037	0	496,037	66.00
66.01 06602	PHYSICAL THERAPY EAST BANK	15,200	0	15,200	66.01
66.10 06601	PHYSICAL THERAPY LIVING CENTER	4,322	0	4,322	66.10
67.00 06700	OCCUPATIONAL THERAPY	302,875	0	302,875	67.00
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	2,842	0	2,842	67.10
68.00 06800	SPEECH PATHOLOGY	29,597	0	29,597	68.00
68.10 06801	SPEECH THERAPY LIVING CENTER	2,154	0	2,154	68.10
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,222,687	0	1,222,687	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	280,585	0	280,585	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	651,938	0	651,938	73.00
76.00 03020	CARDIOLOGY	314,755	0	314,755	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	0	90.00
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	90.10
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	361,769	0	361,769	90.30
90.50 09004	SLEEP DISORDERS CLINIC	9,272	0	9,272	90.50
91.00 09100	EMERGENCY	1,526,941	0	1,526,941	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	27,215,516	0	27,215,516
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168,826	0	168,826	190.00
193.00 19300	NONPAID WORKERS	5,048,970	0	5,048,970	193.00
193.10 19301	HEALTH PROPERTIES	49,299	0	49,299	193.10
193.40 19303	LEIGHTON CENTER	224,125	0	224,125	193.40
193.50 19305	WELLNESS CENTER	19,277	0	19,277	193.50
193.80 19308	UNUSED SPACE	0	0	0	193.80
193.90 19309	OCCUPATIONAL HEALTH	5,651	0	5,651	193.90
193.91 19310	RESEARCH AND PROTOCOL	56	0	56	193.91
193.92 19311	CCOP	9,687	0	9,687	193.92
193.93 19312	RESEARCH ADMIN	20,705	0	20,705	193.93
200.00	Cross Foot Adjustments	0	777,952	0	777,952

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150058

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description		PARAMED ED	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.01	24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	33,540,064	0	33,540,064		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150058

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

Worksheet B-1
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,160,072				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		1,160,072			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,713	9,713	134,972,210		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	91,709	91,709	7,289,833	-44,586,475	5.00
6.00 00600	MAINTENANCE & REPAIRS	3,413	3,413	577,676	0	6.00
7.00 00700	OPERATION OF PLANT	181,380	181,380	2,657,034	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	151	151	0	0	8.00
9.00 00900	HOUSEKEEPING	20,753	20,753	3,098,321	0	9.00
10.00 01000	DIETARY	23,054	23,054	1,721,611	0	10.00
11.00 01100	CAFETERIA	4,487	4,487	1,229,693	0	11.00
13.00 01300	NURSING ADMINISTRATION	17,719	17,719	1,272,141	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	30,004	30,004	1,932,438	0	14.00
15.00 01500	PHARMACY	9,854	9,854	5,806,282	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,471	5,471	2,243,795	0	16.00
17.00 01700	SOCIAL SERVICE	3,509	3,509	2,775,705	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,134,189	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	15,984	15,984	2,392,330	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	3,841	3,841	89,920	0	23.00
23.01 02301	PARAMED ED	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	222,635	222,635	29,724,193	0	30.00
31.00 03100	INTENSIVE CARE UNIT	16,954	16,954	5,241,541	0	31.00
31.01 02060	NEONATAL INTENSIVE CARE UNIT	8,520	8,520	5,040,276	0	31.01
40.00 04000	SUBPROVIDER - I PF	12,480	12,480	1,497,796	0	40.00
41.00 04100	SUBPROVIDER - I RF	11,755	11,755	1,417,432	0	41.00
43.00 04300	NURSERY	4,624	4,624	1,219,632	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	98,777	98,777	12,901,860	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	36,126	36,126	4,192,675	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	59,010	59,010	8,603,607	0	54.00
57.00 05700	CT SCAN	2,887	2,887	1,178,487	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,345	4,345	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	17,241	17,241	1,131,171	0	59.00
60.00 06000	LABORATORY	11,205	11,205	2,544,362	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	10,211	10,211	2,842,555	0	65.00
66.00 06600	PHYSICAL THERAPY	11,909	11,909	2,705,567	0	66.00
66.01 06602	PHYSICAL THERAPY EAST BANK	0	0	1,019,747	0	66.01
66.10 06601	PHYSICAL THERAPY LIVING CENTER	0	0	315,168	0	66.10
67.00 06700	OCCUPATIONAL THERAPY	7,789	7,789	1,451,047	0	67.00
67.10 06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	196,060	0	67.10
68.00 06800	SPEECH PATHOLOGY	348	348	815,932	0	68.00
68.10 06801	SPEECH THERAPY LIVING CENTER	0	0	158,815	0	68.10
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	CARDIOLOGY	7,432	7,432	1,091,590	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.10 09001	FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30 09002	HEMATOLOGY ONCOLOGY CLINIC	9,361	9,361	700,485	0	90.30
90.50 09004	SLEEP DISORDERS CLINIC	0	0	578,006	0	90.50
91.00 09100	EMERGENCY	34,907	34,907	9,407,446	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,009,558	1,009,558	131,196,418	-44,586,475	300,200,698
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,761	4,761	0	0	190.00
193.00 19300	NONPAID WORKERS	138,747	138,747	740,418	0	193.00
193.10 19301	HEALTH PROPERTIES	0	0	1,802,973	0	193.10
193.40 19303	LEIGHTON CENTER	6,302	6,302	0	0	193.40
193.50 19305	WELLNESS CENTER	0	0	946,126	0	193.50
193.80 19308	UNUSED SPACE	0	0	0	0	193.80
193.90 19309	OCCUPATIONAL HEALTH	0	0	0	0	193.90
193.91 19310	RESEARCH AND PROTOCOL	0	0	0	0	193.91
193.92 19311	CCOP	273	273	0	0	193.92

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150058

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

Worksheet B-1

Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
193.93 19312 RESEARCH ADMIN	431	431	286,275	0	384,493	193.93	
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers						201.00	
202.00 Cost to be allocated (per Wkst. B, Part I)	14,430,636	19,109,428	2,502,183		44,586,475	202.00	
203.00 Unit cost multiplier (Wkst. B, Part I)	12.439431	16.472622	0.018539		0.142618	203.00	
204.00 Cost to be allocated (per Wkst. B, Part II)			280,823		2,666,666	204.00	
205.00 Unit cost multiplier (Wkst. B, Part II)			0.002081		0.008530	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150058

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

Worksheet B-1

Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,055,237				6.00
7.00	00700	OPERATION OF PLANT	181,380	873,857			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	151	151	3,144,294		8.00
9.00	00900	HOUSEKEEPING	20,753	20,753	0	97,278	9.00
10.00	01000	DIETARY	23,054	23,054	0	127	343,632
11.00	01100	CAFETERIA	4,487	4,487	0	0	0
13.00	01300	NURSING ADMINISTRATION	17,719	17,719	0	436	0
14.00	01400	CENTRAL SERVICES & SUPPLY	30,004	30,004	31,113	1,625	0
15.00	01500	PHARMACY	9,854	9,854	0	5,447	0
16.00	01600	MEDICAL RECORDS & LIBRARY	5,471	5,471	0	124	0
17.00	01700	SOCIAL SERVICE	3,509	3,509	0	1,607	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	15,984	15,984	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	3,841	3,841	0	0	0
23.01	02301	PARAMED ED	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	222,635	222,635	1,090,312	37,886	283,315
31.00	03100	INTENSIVE CARE UNIT	16,954	16,954	87,514	3,363	26,329
31.01	02060	NEONATAL INTENSIVE CARE UNIT	8,520	8,520	97,477	1,572	0
40.00	04000	SUBPROVIDER - I/PF	12,480	12,480	52,466	283	18,431
41.00	04100	SUBPROVIDER - I/RF	11,755	11,755	116,175	3,752	15,557
43.00	04300	NURSERY	4,624	4,624	29,120	2,162	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	98,777	98,777	417,188	4,501	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,126	36,126	144,376	3,755	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,010	59,010	300,315	7,897	0
57.00	05700	CT SCAN	2,887	2,887	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,345	4,345	12,108	0	0
59.00	05900	CARDIAC CATHETERIZATION	17,241	17,241	120,620	1,296	0
60.00	06000	LABORATORY	11,205	11,205	0	2,603	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	10,211	10,211	0	0	0
66.00	06600	PHYSICAL THERAPY	11,909	11,909	56,237	1,169	0
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	0
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	7,789	7,789	0	55	0
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	348	348	0	340	0
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CARDIOLOGY	7,432	7,432	0	141	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	9,361	9,361	49,964	1,274	0
90.50	09004	SLEEP DISORDERS CLINIC	0	0	20,105	0	0
91.00	09100	EMERGENCY	34,907	34,907	219,782	2,080	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	904,723	723,343	2,844,872	83,495	343,632
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,761	4,761	0	0	0
193.00	19300	NONPAID WORKERS	138,747	138,747	0	13,702	0
193.10	19301	HEALTH PROPERTIES	0	0	0	0	0
193.40	19303	LEIGHTON CENTER	6,302	6,302	0	81	0
193.50	19305	WELLNESS CENTER	0	0	299,422	0	0
193.80	19308	UNUSED SPACE	0	0	0	0	0
193.90	19309	OCCUPATIONAL HEALTH	0	0	0	0	0
193.91	19310	RESEARCH AND PROTOCOL	0	0	0	0	0
193.92	19311	CCOP	273	273	0	0	0
193.93	19312	RESEARCH ADMIN	431	431	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150058

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

Worksheet B-1

Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	5,564,775	16,452,045	1,926,691	7,154,887	5,030,253	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.273484	18.826930	0.612758	73.550926	14.638488	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	141,422	5,389,584	19,672	786,917	849,761	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.134019	6.167581	0.006256	8.089362	2.472881	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150058

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

Worksheet B-1
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,661,592					11.00
13.00	01300	34,897	1,340,480				13.00
14.00	01400	85,100	18	100			14.00
15.00	01500	132,798	0	0	14,981,490		15.00
16.00	01600	88,681	7,154	0	0	3,197	16.00
17.00	01700	90,962	4,947	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	92,817	0	0	0	0	22.00
23.00	02300	3,151	0	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,055,949	588,134	0	6,223	523	30.00
31.00	03100	156,721	114,534	0	271	40	31.00
31.01	02060	123,349	89,300	0	1,580	14	31.01
40.00	04000	63,877	23,924	0	0	28	40.00
41.00	04100	43,842	24,943	0	267	13	41.00
43.00	04300	36,602	21,433	0	34	10	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	364,665	181,405	0	3,172	734	50.00
52.00	05200	125,671	81,024	0	19	0	52.00
54.00	05400	252,748	33,401	0	4,877	552	54.00
57.00	05700	30,649	0	0	15	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	31,148	10,824	0	798	0	59.00
60.00	06000	110,127	0	0	0	248	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	83,208	0	0	3,313	0	65.00
66.00	06600	67,173	0	0	661	345	66.00
66.01	06602	31,756	0	0	0	0	66.01
66.10	06601	7,215	0	0	0	0	66.10
67.00	06700	38,020	0	0	0	85	67.00
67.10	06701	5,748	0	0	24	0	67.10
68.00	06800	20,439	0	0	0	40	68.00
68.10	06801	3,459	0	0	0	0	68.10
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	100	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	14,941,651	0	73.00
76.00	03020	25,371	7,916	0	646	232	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.10	09001	0	0	0	0	0	90.10
90.30	09002	17,536	12,349	0	154	0	90.30
90.50	09004	17,074	0	0	0	0	90.50
91.00	09100	257,318	127,135	0	12,799	333	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,498,071	1,328,441	100	14,976,504	3,197	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
193.00	19300	37,400	1,650	0	3,840	0	193.00
193.10	19301	76,233	7,676	0	1,024	0	193.10
193.40	19303	0	0	0	0	0	193.40
193.50	19305	41,442	0	0	0	0	193.50
193.80	19308	0	0	0	0	0	193.80
193.90	19309	0	0	0	0	0	193.90
193.91	19310	421	76	0	0	0	193.91
193.92	19311	0	0	0	122	0	193.92
193.93	19312	8,025	2,637	0	0	0	193.93
200.00							200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150058

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

Worksheet B-1

Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,180,424	3,202,389	8,983,668	16,384,208	4,505,253	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.322380	2.388987	89,836.680000	1.093630	1,409.212699	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	168,568	652,127	1,138,267	526,485	238,129	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.046037	0.486488	11,382.670000	0.035142	74.485142	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150058

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

Worksheet B-1
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)	PARAMED (ASSIGNED TIME)	23.01
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	58,148					17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	2,124				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		2,124			22.00
23.00 02300 PARAMED PRGM-(SPECIFY)	0			100		23.00
23.01 02301 PARAMED ED	0			0	0	23.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	35,889	1,691	1,691	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	3,437	0	0	0	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	2,021	17	17	0	0	31.01
40.00 04000 SUBPROVIDER - IPF	3,443	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	1,794	0	0	0	0	41.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	14	133	133	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	144	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	27	27	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	54	54	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 RADIOLOGY	0	59	59	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	958	4	4	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00 09100 EMERGENCY	8,653	124	124	100	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	56,353	2,109	2,109	100	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
193.00 19300 NONPAID WORKERS	0	15	15	0	0	193.00
193.10 19301 HEALTH PROPERTIES	0	0	0	0	0	193.10
193.40 19303 LEIGHTON CENTER	0	0	0	0	0	193.40
193.50 19305 WELLNESS CENTER	0	0	0	0	0	193.50
193.80 19308 UNUSED SPACE	0	0	0	0	0	193.80
193.90 19309 OCCUPATIONAL HEALTH	1,795	0	0	0	0	193.90
193.91 19310 RESEARCH AND PROTOCOL	0	0	0	0	0	193.91
193.92 19311 CCOP	0	0	0	0	0	193.92
193.93 19312 RESEARCH ADMIN	0	0	0	0	0	193.93

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150058

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

Worksheet B-1
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)	PARAMED (ASSIGNED TIME)	
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		17.00	21.00			
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)	4,815,201	2,483,772	6,469,469	371,984	0 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	82.809400	1,169.384181	3,045.889360	3,719.840000	0.000000 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	183,061	22,983	617,303	137,666	0 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.148191	10.820621	290.632298	1,376.660000	0.000000 205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 9:20 am	
			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	74,887,763	74,887,763	0	74,887,763	30.00
31.00	03100 INTENSIVE CARE UNIT	11,868,509	11,868,509	0	11,868,509	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT	9,138,991	9,138,991	12,069	9,151,060	31.01
40.00	04000 SUBPROVIDER - I PF	4,084,928	4,084,928	0	4,084,928	40.00
41.00	04100 SUBPROVIDER - I RF	3,716,843	3,716,843	0	3,716,843	41.00
43.00	04300 NURSERY	2,348,558	2,348,558	0	2,348,558	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	33,734,091	33,734,091	23,035	33,757,126	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9,626,231	9,626,231	0	9,626,231	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	20,927,625	20,927,625	41,258	20,968,883	54.00
57.00	05700 CT SCAN	2,175,260	2,175,260	0	2,175,260	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	945,372	945,372	0	945,372	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,584,688	3,584,688	2,778	3,587,466	59.00
60.00	06000 LABORATORY	15,623,669	15,623,669	0	15,623,669	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	5,412,112	5,412,112	0	5,412,112	65.00
66.00	06600 PHYSICAL THERAPY	5,259,847	5,259,847	26,990	5,286,837	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	1,566,179	1,566,179	0	1,566,179	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	448,982	448,982	0	448,982	66.10
67.00	06700 OCCUPATIONAL THERAPY	2,607,679	2,607,679	0	2,607,679	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	292,283	292,283	0	292,283	67.10
68.00	06800 SPEECH PATHOLOGY	1,298,542	1,298,542	0	1,298,542	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	224,119	224,119	0	224,119	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20,291,947	20,291,947	0	20,291,947	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	37,585,137	37,585,137	0	37,585,137	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	33,332,990	33,332,990	0	33,332,990	73.00
76.00	03020 RADIOLOGY	4,202,618	4,202,618	22,316	4,224,934	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	1,833,642	1,833,642	0	1,833,642	90.30
90.50	09004 SLEEP DISORDERS CLINIC	976,515	976,515	6,692	983,207	90.50
91.00	09100 EMERGENCY	21,006,105	21,006,105	497,787	21,503,892	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,187,626	7,187,626	0	7,187,626	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	336,188,851	336,188,851	632,925	336,821,776	200.00
201.00	Less Observation Beds	7,187,626	7,187,626		7,187,626	201.00
202.00	Total (see instructions)	329,001,225	329,001,225	632,925	329,634,150	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150058		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/29/2015 9:20 am	
			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	156,111,351		156,111,351			30.00
31.00	03100	INTENSIVE CARE UNIT	29,836,085		29,836,085			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	22,305,434		22,305,434			31.01
40.00	04000	SUBPROVIDER - I/PF	4,892,279		4,892,279			40.00
41.00	04100	SUBPROVIDER - I/RF	9,678,074		9,678,074			41.00
43.00	04300	NURSERY	3,866,514		3,866,514			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,973,871	58,320,694	109,294,565	0.308653	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,303,481	1,633,297	19,936,778	0.482838	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,714,102	71,081,936	102,796,038	0.203584	0.000000	54.00
57.00	05700	CT SCAN	17,837,387	36,523,068	54,360,455	0.040015	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,199,371	339,833	1,539,204	0.614195	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,517,516	26,473,406	44,990,922	0.079676	0.000000	59.00
60.00	06000	LABORATORY	68,933,793	33,456,807	102,390,600	0.152589	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	34,567,674	3,268,248	37,835,922	0.143042	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,664,936	4,339,845	12,004,781	0.438146	0.000000	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	3,072	4,519,948	4,523,020	0.346268	0.000000	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	2,389	1,271,957	1,274,346	0.352323	0.000000	66.10
67.00	06700	OCCUPATIONAL THERAPY	4,596,730	1,671,884	6,268,614	0.415990	0.000000	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	735	888,891	889,626	0.328546	0.000000	67.10
68.00	06800	SPEECH PATHOLOGY	2,031,551	1,990,895	4,022,446	0.322824	0.000000	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	181	791,730	791,911	0.283010	0.000000	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,223,906	19,890,796	75,114,702	0.270146	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,239,657	48,845,725	153,085,382	0.245517	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	92,028,976	56,320,634	148,349,610	0.224692	0.000000	73.00
76.00	03020	CARDIOLOGY	6,142,904	5,506,768	11,649,672	0.360750	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	52,997	1,297,814	1,350,811	1.357438	0.000000	90.30
90.50	09004	SLEEP DISORDERS CLINIC	6,764	3,897,828	3,904,592	0.250094	0.000000	90.50
91.00	09100	EMERGENCY	12,980,145	30,697,825	43,677,970	0.480931	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	16,207,399	0.443478	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	753,711,875	429,237,228	1,182,949,103			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	753,711,875	429,237,228	1,182,949,103			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		31.01
40.00	04000	SUBPROVIDER - I PF		40.00
41.00	04100	SUBPROVIDER - I RF		41.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.308864	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482838	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203985	54.00
57.00	05700	CT SCAN	0.040015	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.614195	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079738	59.00
60.00	06000	LABORATORY	0.152589	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.143042	65.00
66.00	06600	PHYSICAL THERAPY	0.440394	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.346268	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.352323	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.415990	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.328546	67.10
68.00	06800	SPEECH PATHOLOGY	0.322824	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283010	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245517	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224692	73.00
76.00	03020	CARDIOLOGY	0.362665	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.357438	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.251808	90.50
91.00	09100	EMERGENCY	0.492328	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443478	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 9:20 am		
		Title XIX	Hospital	PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		74,887,763	0	74,887,763	30.00
31.00	03100 INTENSIVE CARE UNIT		11,868,509	0	11,868,509	31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT		9,138,991	12,069	9,151,060	31.01
40.00	04000 SUBPROVIDER - I PF		4,084,928	0	4,084,928	40.00
41.00	04100 SUBPROVIDER - I RF		3,716,843	0	3,716,843	41.00
43.00	04300 NURSERY		2,348,558	0	2,348,558	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		33,734,091	23,035	33,757,126	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		9,626,231	0	9,626,231	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		20,927,625	41,258	20,968,883	54.00
57.00	05700 CT SCAN		2,175,260	0	2,175,260	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		945,372	0	945,372	58.00
59.00	05900 CARDIAC CATHETERIZATION		3,584,688	2,778	3,587,466	59.00
60.00	06000 LABORATORY		15,623,669	0	15,623,669	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	5,412,112	0	5,412,112	65.00
66.00	06600 PHYSICAL THERAPY	0	5,259,847	26,990	5,286,837	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	1,566,179	0	1,566,179	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	448,982	0	448,982	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	2,607,679	0	2,607,679	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	292,283	0	292,283	67.10
68.00	06800 SPEECH PATHOLOGY	0	1,298,542	0	1,298,542	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	224,119	0	224,119	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		20,291,947	0	20,291,947	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		37,585,137	0	37,585,137	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		33,332,990	0	33,332,990	73.00
76.00	03020 RADIOLOGY		4,202,618	22,316	4,224,934	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC		0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC		1,833,642	0	1,833,642	90.30
90.50	09004 SLEEP DISORDERS CLINIC		976,515	6,692	983,207	90.50
91.00	09100 EMERGENCY		21,006,105	497,787	21,503,892	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		7,187,626	0	7,187,626	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		336,188,851	632,925	336,821,776	200.00
201.00	Less Observation Beds		7,187,626		7,187,626	201.00
202.00	Total (see instructions)		329,001,225	632,925	329,634,150	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150058		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/29/2015 9:20 am	
			Title XIX		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	156,111,351		156,111,351			30.00
31.00	03100	INTENSIVE CARE UNIT	29,836,085		29,836,085			31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	22,305,434		22,305,434			31.01
40.00	04000	SUBPROVIDER - I/PF	4,892,279		4,892,279			40.00
41.00	04100	SUBPROVIDER - I/RF	9,678,074		9,678,074			41.00
43.00	04300	NURSERY	3,866,514		3,866,514			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,973,871	58,320,694	109,294,565	0.308653	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,303,481	1,633,297	19,936,778	0.482838	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,714,102	71,081,936	102,796,038	0.203584	0.000000	54.00
57.00	05700	CT SCAN	17,837,387	36,523,068	54,360,455	0.040015	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,199,371	339,833	1,539,204	0.614195	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,517,516	26,473,406	44,990,922	0.079676	0.000000	59.00
60.00	06000	LABORATORY	68,933,793	33,456,807	102,390,600	0.152589	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	34,567,674	3,268,248	37,835,922	0.143042	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,664,936	4,339,845	12,004,781	0.438146	0.000000	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	3,072	4,519,948	4,523,020	0.346268	0.000000	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	2,389	1,271,957	1,274,346	0.352323	0.000000	66.10
67.00	06700	OCCUPATIONAL THERAPY	4,596,730	1,671,884	6,268,614	0.415990	0.000000	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	735	888,891	889,626	0.328546	0.000000	67.10
68.00	06800	SPEECH PATHOLOGY	2,031,551	1,990,895	4,022,446	0.322824	0.000000	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	181	791,730	791,911	0.283010	0.000000	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,223,906	19,890,796	75,114,702	0.270146	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	104,239,657	48,845,725	153,085,382	0.245517	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	92,028,976	56,320,634	148,349,610	0.224692	0.000000	73.00
76.00	03020	CARDIOLOGY	6,142,904	5,506,768	11,649,672	0.360750	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0.000000	0.000000	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	52,997	1,297,814	1,350,811	1.357438	0.000000	90.30
90.50	09004	SLEEP DISORDERS CLINIC	6,764	3,897,828	3,904,592	0.250094	0.000000	90.50
91.00	09100	EMERGENCY	12,980,145	30,697,825	43,677,970	0.480931	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	16,207,399	0.443478	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	753,711,875	429,237,228	1,182,949,103			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	753,711,875	429,237,228	1,182,949,103			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 9:20 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
31.01	02060 NEONATAL INTENSIVE CARE UNIT			31.01
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.308864		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.482838		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.203985		54.00
57.00	05700 CT SCAN	0.040015		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.614195		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.079738		59.00
60.00	06000 LABORATORY	0.152589		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.143042		65.00
66.00	06600 PHYSICAL THERAPY	0.440394		66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0.346268		66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0.352323		66.10
67.00	06700 OCCUPATIONAL THERAPY	0.415990		67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0.328546		67.10
68.00	06800 SPEECH PATHOLOGY	0.322824		68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0.283010		68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270146		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.245517		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.224692		73.00
76.00	03020 CARDIOLOGY	0.362665		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.10	09001 FAMILY PRACTICE CLINIC	0.000000		90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	1.357438		90.30
90.50	09004 SLEEP DISORDERS CLINIC	0.251808		90.50
91.00	09100 EMERGENCY	0.492328		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.443478		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 150058

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

Worksheet C Part II Date/Time Prepared: 5/29/2015 9:20 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,734,091	3,921,849	29,812,242	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,626,231	1,418,594	8,207,637	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,927,625	2,363,648	18,563,977	0	0	54.00
57.00	05700	CT SCAN	2,175,260	121,172	2,054,088	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	945,372	159,299	786,073	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,584,688	649,560	2,935,128	0	0	59.00
60.00	06000	LABORATORY	15,623,669	554,780	15,068,889	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,412,112	407,767	5,004,345	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,259,847	496,037	4,763,810	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	1,566,179	15,200	1,550,979	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	448,982	4,322	444,660	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	2,607,679	302,875	2,304,804	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	292,283	2,842	289,441	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	1,298,542	29,597	1,268,945	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	224,119	2,154	221,965	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,291,947	1,222,687	19,069,260	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,585,137	280,585	37,304,552	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,332,990	651,938	32,681,052	0	0	73.00
76.00	03020	CARDIOLOGY	4,202,618	314,755	3,887,863	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1,833,642	361,769	1,471,873	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	976,515	9,272	967,243	0	0	90.50
91.00	09100	EMERGENCY	21,006,105	1,526,941	19,479,164	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,187,626	942,873	6,244,753	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	230,143,259	15,760,516	214,382,743	0	0	200.00
201.00		Less Observation Beds	7,187,626	942,873	6,244,753	0	0	201.00
202.00		Total (line 200 minus line 201)	222,955,633	14,817,643	208,137,990	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Prepared: 5/29/2015 9:20 am
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	33,734,091	109,294,565	0.308653	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9,626,231	19,936,778	0.482838	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	20,927,625	102,796,038	0.203584	54.00
57.00	05700 CT SCAN	2,175,260	54,360,455	0.040015	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	945,372	1,539,204	0.614195	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,584,688	44,990,922	0.079676	59.00
60.00	06000 LABORATORY	15,623,669	102,390,600	0.152589	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	60.01
65.00	06500 RESPIRATORY THERAPY	5,412,112	37,835,922	0.143042	65.00
66.00	06600 PHYSICAL THERAPY	5,259,847	12,004,781	0.438146	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	1,566,179	4,523,020	0.346268	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	448,982	1,274,346	0.352323	66.10
67.00	06700 OCCUPATIONAL THERAPY	2,607,679	6,268,614	0.415990	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	292,283	889,626	0.328546	67.10
68.00	06800 SPEECH PATHOLOGY	1,298,542	4,022,446	0.322824	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	224,119	791,911	0.283010	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20,291,947	75,114,702	0.270146	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	37,585,137	153,085,382	0.245517	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	33,332,990	148,349,610	0.224692	73.00
76.00	03020 CARDIOLOGY	4,202,618	11,649,672	0.360750	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0.000000	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	1,833,642	1,350,811	1.357438	90.30
90.50	09004 SLEEP DISORDERS CLINIC	976,515	3,904,592	0.250094	90.50
91.00	09100 EMERGENCY	21,006,105	43,677,970	0.480931	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,187,626	16,207,399	0.443478	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	230,143,259	956,259,366		200.00
201.00	Less Observation Beds	7,187,626	0		201.00
202.00	Total (line 200 minus line 201)	222,955,633	956,259,366		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIII	Hospital	PPS

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,823,812	0	9,823,812	84,081	116.84 30.00
31.00	INTENSIVE CARE UNIT	852,983		852,983	7,156	119.20 31.00
31.01	NEONATAL INTENSIVE CARE UNIT	442,503		442,503	7,978	55.47 31.01
40.00	SUBPROVIDER - IPF	541,120	0	541,120	5,041	107.34 40.00
41.00	SUBPROVIDER - IRF	526,755	0	526,755	4,212	125.06 41.00
43.00	NURSERY	210,700		210,700	4,725	44.59 43.00
200.00	Total (Lines 30-199)	12,397,873		12,397,873	113,193	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	24,387	2,849,377 30.00
31.00	INTENSIVE CARE UNIT	3,055	364,156 31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0 31.01
40.00	SUBPROVIDER - IPF	3,418	366,888 40.00
41.00	SUBPROVIDER - IRF	1,424	178,085 41.00
43.00	NURSERY	0	0 43.00
200.00	Total (Lines 30-199)	32,284	3,758,506 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 9:20 am
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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	3,921,849	109,294,565	0.035883	19,628,039	704,313	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,418,594	19,936,778	0.071155	121,738	8,662	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,363,648	102,796,038	0.022994	12,292,679	282,658	54.00
57.00	05700	CT SCAN	121,172	54,360,455	0.002229	5,953,075	13,269	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,299	1,539,204	0.103494	635,996	65,822	58.00
59.00	05900	CARDIAC CATHETERIZATION	649,560	44,990,922	0.014438	4,674,303	67,488	59.00
60.00	06000	LABORATORY	554,780	102,390,600	0.005418	23,190,095	125,644	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	407,767	37,835,922	0.010777	9,635,955	103,847	65.00
66.00	06600	PHYSICAL THERAPY	496,037	12,004,781	0.041320	2,457,658	101,550	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	15,200	4,523,020	0.003361	1,620	5	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	4,322	1,274,346	0.003392	1,683	6	66.10
67.00	06700	OCCUPATIONAL THERAPY	302,875	6,268,614	0.048316	1,047,678	50,620	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	2,842	889,626	0.003195	518	2	67.10
68.00	06800	SPEECH PATHOLOGY	29,597	4,022,446	0.007358	369,821	2,721	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	2,154	791,911	0.002720	128	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,222,687	75,114,702	0.016278	22,466,551	365,711	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	280,585	153,085,382	0.001833	38,833,902	71,183	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	651,938	148,349,610	0.004395	29,702,828	130,544	73.00
76.00	03020	CARDIOLOGY	314,755	11,649,672	0.027018	2,658,915	71,839	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	361,769	1,350,811	0.267816	14	4	90.30
90.50	09004	SLEEP DISORDERS CLINIC	9,272	3,904,592	0.002375	0	0	90.50
91.00	09100	EMERGENCY	1,526,941	43,677,970	0.034959	6,145,388	214,837	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	942,873	16,207,399	0.058175	0	0	92.00
200.00		Total (lines 50-199)	15,760,516	956,259,366		179,818,584	2,380,725	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part III Date/Time Prepared: 5/29/2015 9:20 am
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Cost Center Description			Title XVIII				Hospital	
			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)	PPS
			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
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	84,081	0.00	24,387	0		30.00
31.00	03100	INTENSIVE CARE UNIT	7,156	0.00	3,055	0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	7,978	0.00	0	0		31.01
40.00	04000	SUBPROVIDER - I PF	5,041	0.00	3,418	0		40.00
41.00	04100	SUBPROVIDER - I RF	4,212	0.00	1,424	0		41.00
43.00	04300	NURSERY	4,725	0.00	0	0		43.00
200.00		Total (lines 30-199)	113,193		32,284	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
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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	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100	EMERGENCY	0	0	371,984	0	371,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	371,984	0	371,984	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
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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	109,294,565	0.000000	0.000000	19,628,039	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	19,936,778	0.000000	0.000000	121,738	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	102,796,038	0.000000	0.000000	12,292,679	54.00
57.00	05700 CT SCAN	0	54,360,455	0.000000	0.000000	5,953,075	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,539,204	0.000000	0.000000	635,996	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	44,990,922	0.000000	0.000000	4,674,303	59.00
60.00	06000 LABORATORY	0	102,390,600	0.000000	0.000000	23,190,095	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	37,835,922	0.000000	0.000000	9,635,955	65.00
66.00	06600 PHYSICAL THERAPY	0	12,004,781	0.000000	0.000000	2,457,658	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	4,523,020	0.000000	0.000000	1,620	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	1,274,346	0.000000	0.000000	1,683	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	6,268,614	0.000000	0.000000	1,047,678	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	889,626	0.000000	0.000000	518	67.10
68.00	06800 SPEECH PATHOLOGY	0	4,022,446	0.000000	0.000000	369,821	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	791,911	0.000000	0.000000	128	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,114,702	0.000000	0.000000	22,466,551	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	153,085,382	0.000000	0.000000	38,833,902	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	148,349,610	0.000000	0.000000	29,702,828	73.00
76.00	03020 CARDIOLOGY	0	11,649,672	0.000000	0.000000	2,658,915	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	0.000000	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	1,350,811	0.000000	0.000000	14	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	3,904,592	0.000000	0.000000	0	90.50
91.00	09100 EMERGENCY	371,984	43,677,970	0.008517	0.008517	6,145,388	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	371,984	956,259,366			179,818,584	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
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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)	Hospital	PPS
Title XVIII						
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	12,535,493	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	9,207	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	19,783,296	0		54.00
57.00	05700 CT SCAN	0	7,820,704	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	47,673	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	6,250,778	0		59.00
60.00	06000 LABORATORY	0	6,838,613	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0	657,345	0		65.00
66.00	06600 PHYSICAL THERAPY	0	1,226,047	0		66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	837,000	0		66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	374,151	0		66.10
67.00	06700 OCCUPATIONAL THERAPY	0	117,379	0		67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	203,474	0		67.10
68.00	06800 SPEECH PATHOLOGY	0	93,784	0		68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	172,158	0		68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,696,005	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	16,417,796	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13,983,307	0		73.00
76.00	03020 CARDIOLOGY	0	1,396,321	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0		90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0		90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	682,288	0		90.50
91.00	09100 EMERGENCY	52,340	6,538,925	55,692		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,109,780	0		92.00
200.00	Total (lines 50-199)	52,340	105,791,524	55,692		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 9:20 am
		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	0.308653	12,535,493	8,112	0	3,869,118	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482838	9,207	6	0	4,445	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203584	19,783,296	12,801	0	4,027,563	54.00
57.00	05700	CT SCAN	0.040015	7,820,704	5,061	0	312,945	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.614195	47,673	31	0	29,281	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079676	6,250,778	4,045	0	498,037	59.00
60.00	06000	LABORATORY	0.152589	6,838,613	4,425	0	1,043,497	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.143042	657,345	425	0	94,028	65.00
66.00	06600	PHYSICAL THERAPY	0.438146	1,226,047	793	0	537,188	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.346268	837,000	542	0	289,826	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.352323	374,151	242	0	131,822	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.415990	117,379	76	0	48,828	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.328546	203,474	132	0	66,851	67.10
68.00	06800	SPEECH PATHOLOGY	0.322824	93,784	61	0	30,276	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283010	172,158	111	0	48,722	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270146	7,696,005	4,980	0	2,079,045	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245517	16,417,796	10,624	0	4,030,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224692	13,983,307	9,048	0	3,141,937	73.00
76.00	03020	CARDIOLOGY	0.360750	1,396,321	904	0	503,723	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.357438	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.250094	682,288	441	0	170,636	90.50
91.00	09100	EMERGENCY	0.480931	6,538,925	4,231	0	3,144,772	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443478	2,109,780	1,365	0	935,641	92.00
200.00		Subtotal (see instructions)		105,791,524	68,456	0	25,039,029	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		105,791,524	68,456	0	25,039,029	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	2,504	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,606	0		54.00
57.00 05700 CT SCAN	203	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	19	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	322	0		59.00
60.00 06000 LABORATORY	675	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	61	0		65.00
66.00 06600 PHYSICAL THERAPY	347	0		66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	188	0		66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	85	0		66.10
67.00 06700 OCCUPATIONAL THERAPY	32	0		67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	43	0		67.10
68.00 06800 SPEECH PATHOLOGY	20	0		68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	31	0		68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,345	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,608	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,033	0		73.00
76.00 03020 RADIOLOGY	326	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0		90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0		90.30
90.50 09004 SLEEP DISORDERS CLINIC	110	0		90.50
91.00 09100 EMERGENCY	2,035	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	605	0		92.00
200.00 Subtotal (see instructions)	16,201	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	16,201	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 9:20 am		
				Title XVIIII	Subprovider - IPF	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,921,849	109,294,565	0.035883	96,832	3,475	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,418,594	19,936,778	0.071155	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,363,648	102,796,038	0.022994	32,464	746	54.00
57.00	05700	CT SCAN	121,172	54,360,455	0.002229	14,521	32	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,299	1,539,204	0.103494	1,066	110	58.00
59.00	05900	CARDIAC CATHETERIZATION	649,560	44,990,922	0.014438	0	0	59.00
60.00	06000	LABORATORY	554,780	102,390,600	0.005418	304,614	1,650	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	407,767	37,835,922	0.010777	5,837	63	65.00
66.00	06600	PHYSICAL THERAPY	496,037	12,004,781	0.041320	261,258	10,795	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	15,200	4,523,020	0.003361	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	4,322	1,274,346	0.003392	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	302,875	6,268,614	0.048316	120,724	5,833	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	2,842	889,626	0.003195	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	29,597	4,022,446	0.007358	2,258	17	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	2,154	791,911	0.002720	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,222,687	75,114,702	0.016278	42,976	700	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	280,585	153,085,382	0.001833	4,875	9	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	651,938	148,349,610	0.004395	1,294,661	5,690	73.00
76.00	03020	CARDIOLOGY	314,755	11,649,672	0.027018	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	361,769	1,350,811	0.267816	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	9,272	3,904,592	0.002375	0	0	90.50
91.00	09100	EMERGENCY	1,526,941	43,677,970	0.034959	9,175	321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0	0	92.00
200.00		Total (lines 50-199)	14,817,643	956,259,366		2,191,261	29,441	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058 Component CCN: 15S058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
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
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CARDIOLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	0	90.50
91.00	09100	EMERGENCY	0	0	371,984	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	371,984	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058 Component CCN: 15S058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	109,294,565	0.000000	0.000000	96,832	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	19,936,778	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	102,796,038	0.000000	0.000000	32,464	54.00
57.00	05700 CT SCAN	0	54,360,455	0.000000	0.000000	14,521	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,539,204	0.000000	0.000000	1,066	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	44,990,922	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	102,390,600	0.000000	0.000000	304,614	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	37,835,922	0.000000	0.000000	5,837	65.00
66.00	06600 PHYSICAL THERAPY	0	12,004,781	0.000000	0.000000	261,258	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	4,523,020	0.000000	0.000000	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	1,274,346	0.000000	0.000000	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	6,268,614	0.000000	0.000000	120,724	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	889,626	0.000000	0.000000	0	67.10
68.00	06800 SPEECH PATHOLOGY	0	4,022,446	0.000000	0.000000	2,258	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	791,911	0.000000	0.000000	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,114,702	0.000000	0.000000	42,976	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	153,085,382	0.000000	0.000000	4,875	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	148,349,610	0.000000	0.000000	1,294,661	73.00
76.00	03020 CARDIOLOGY	0	11,649,672	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	0.000000	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	1,350,811	0.000000	0.000000	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	3,904,592	0.000000	0.000000	0	90.50
91.00	09100 EMERGENCY	371,984	43,677,970	0.008517	0.008517	9,175	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	371,984	956,259,366			2,191,261	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
	Component CCN: 15S058	Title XVIII	Subprovider - IPF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03020 RADIOLOGY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	90.50
91.00 09100 EMERGENCY	78	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	78	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 9:20 am		
				Component CCN: 15T058		Title XVIII		
				Subprovider - IRF		PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,921,849	109,294,565	0.035883	12,719	456	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,418,594	19,936,778	0.071155	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,363,648	102,796,038	0.022994	107,370	2,469	54.00
57.00	05700	CT SCAN	121,172	54,360,455	0.002229	56,890	127	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,299	1,539,204	0.103494	7,885	816	58.00
59.00	05900	CARDIAC CATHETERIZATION	649,560	44,990,922	0.014438	0	0	59.00
60.00	06000	LABORATORY	554,780	102,390,600	0.005418	258,080	1,398	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	407,767	37,835,922	0.010777	112,703	1,215	65.00
66.00	06600	PHYSICAL THERAPY	496,037	12,004,781	0.041320	595,171	24,592	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	15,200	4,523,020	0.003361	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	4,322	1,274,346	0.003392	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	302,875	6,268,614	0.048316	584,174	28,225	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	2,842	889,626	0.003195	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	29,597	4,022,446	0.007358	338,093	2,488	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	2,154	791,911	0.002720	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,222,687	75,114,702	0.016278	125,137	2,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	280,585	153,085,382	0.001833	8,385	15	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	651,938	148,349,610	0.004395	783,584	3,444	73.00
76.00	03020	CARDIOLOGY	314,755	11,649,672	0.027018	11,315	306	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	361,769	1,350,811	0.267816	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	9,272	3,904,592	0.002375	0	0	90.50
91.00	09100	EMERGENCY	1,526,941	43,677,970	0.034959	972	34	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0	0	92.00
200.00		Total (lines 50-199)	14,817,643	956,259,366		3,002,478	67,622	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058 Component CCN: 15T058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 CARDIOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100 EMERGENCY	0	0	371,984	0	371,984	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	371,984	0	371,984	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058 Component CCN: 15T058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	109,294,565	0.000000	0.000000	12,719	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	19,936,778	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	102,796,038	0.000000	0.000000	107,370	54.00
57.00	05700 CT SCAN	0	54,360,455	0.000000	0.000000	56,890	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,539,204	0.000000	0.000000	7,885	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	44,990,922	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	102,390,600	0.000000	0.000000	258,080	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	37,835,922	0.000000	0.000000	112,703	65.00
66.00	06600 PHYSICAL THERAPY	0	12,004,781	0.000000	0.000000	595,171	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	4,523,020	0.000000	0.000000	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	1,274,346	0.000000	0.000000	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	6,268,614	0.000000	0.000000	584,174	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	889,626	0.000000	0.000000	0	67.10
68.00	06800 SPEECH PATHOLOGY	0	4,022,446	0.000000	0.000000	338,093	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	791,911	0.000000	0.000000	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,114,702	0.000000	0.000000	125,137	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	153,085,382	0.000000	0.000000	8,385	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	148,349,610	0.000000	0.000000	783,584	73.00
76.00	03020 CARDIOLOGY	0	11,649,672	0.000000	0.000000	11,315	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	0.000000	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	1,350,811	0.000000	0.000000	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	3,904,592	0.000000	0.000000	0	90.50
91.00	09100 EMERGENCY	371,984	43,677,970	0.008517	0.008517	972	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	371,984	956,259,366			3,002,478	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
	Component CCN: 15T058	Title XVIII	Subprovider - IRF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03020 RADIOLOGY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	90.50
91.00 09100 EMERGENCY	8	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	8	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I Date/Time Prepared: 5/29/2015 9:20 am
		Title XIX	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,823,812	0	9,823,812	84,081	116.84	30.00
31.00	INTENSIVE CARE UNIT	852,983		852,983	7,156	119.20	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	442,503		442,503	7,978	55.47	31.01
40.00	SUBPROVIDER - IPF	541,120	0	541,120	5,041	107.34	40.00
41.00	SUBPROVIDER - IRF	526,755	0	526,755	4,212	125.06	41.00
43.00	NURSERY	210,700		210,700	4,725	44.59	43.00
200.00	Total (Lines 30-199)	12,397,873		12,397,873	113,193		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	11,784	1,376,843				
31.00	INTENSIVE CARE UNIT	0	0				
31.01	NEONATAL INTENSIVE CARE UNIT	0	0				
40.00	SUBPROVIDER - IPF	1,431	153,604				
41.00	SUBPROVIDER - IRF	625	78,163				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	13,840	1,608,610				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 9:20 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,921,849	109,294,565	0.035883	11,027,857	395,713	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,418,594	19,936,778	0.071155	10,625,363	756,048	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,363,648	102,796,038	0.022994	5,625,865	129,361	54.00
57.00	05700	CT SCAN	121,172	54,360,455	0.002229	2,529,357	5,638	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,299	1,539,204	0.103494	205,128	21,230	58.00
59.00	05900	CARDIAC CATHETERIZATION	649,560	44,990,922	0.014438	1,375,372	19,858	59.00
60.00	06000	LABORATORY	554,780	102,390,600	0.005418	13,463,212	72,944	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	407,767	37,835,922	0.010777	10,951,926	118,029	65.00
66.00	06600	PHYSICAL THERAPY	496,037	12,004,781	0.041320	665,970	27,518	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	15,200	4,523,020	0.003361	352	1	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	4,322	1,274,346	0.003392	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	302,875	6,268,614	0.048316	394,711	19,071	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	2,842	889,626	0.003195	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	29,597	4,022,446	0.007358	194,925	1,434	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	2,154	791,911	0.002720	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,222,687	75,114,702	0.016278	169,440	2,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	280,585	153,085,382	0.001833	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	651,938	148,349,610	0.004395	17,325,881	76,147	73.00
76.00	03020	CARDIOLOGY	314,755	11,649,672	0.027018	748,001	20,209	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	361,769	1,350,811	0.267816	48,338	12,946	90.30
90.50	09004	SLEEP DISORDERS CLINIC	9,272	3,904,592	0.002375	3,158	8	90.50
91.00	09100	EMERGENCY	1,526,941	43,677,970	0.034959	2,848,119	99,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	942,873	16,207,399	0.058175	0	0	92.00
200.00		Total (lines 50-199)	15,760,516	956,259,366		78,202,975	1,778,480	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part III Date/Time Prepared: 5/29/2015 9:20 am
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Cost Center Description			Title XIX				Hospital	
			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)	PPS
			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
31.01	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	31.01
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	84,081	0.00	11,784	0		30.00
31.00	03100	INTENSIVE CARE UNIT	7,156	0.00	0	0		31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT	7,978	0.00	0	0		31.01
40.00	04000	SUBPROVIDER - I PF	5,041	0.00	1,431	0		40.00
41.00	04100	SUBPROVIDER - I RF	4,212	0.00	625	0		41.00
43.00	04300	NURSERY	4,725	0.00	0	0		43.00
200.00		Total (lines 30-199)	113,193		13,840	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
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Cost Center Description		Title XIX				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00	09100	EMERGENCY	0	0	371,984	0	371,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	371,984	0	371,984	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	109,294,565	0.000000	0.000000	11,027,857	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,936,778	0.000000	0.000000	10,625,363	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	102,796,038	0.000000	0.000000	5,625,865	54.00
57.00	05700	CT SCAN	0	54,360,455	0.000000	0.000000	2,529,357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,539,204	0.000000	0.000000	205,128	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	44,990,922	0.000000	0.000000	1,375,372	59.00
60.00	06000	LABORATORY	0	102,390,600	0.000000	0.000000	13,463,212	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	37,835,922	0.000000	0.000000	10,951,926	65.00
66.00	06600	PHYSICAL THERAPY	0	12,004,781	0.000000	0.000000	665,970	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	4,523,020	0.000000	0.000000	352	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	1,274,346	0.000000	0.000000	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	6,268,614	0.000000	0.000000	394,711	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	889,626	0.000000	0.000000	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	4,022,446	0.000000	0.000000	194,925	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	791,911	0.000000	0.000000	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,114,702	0.000000	0.000000	169,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	153,085,382	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	148,349,610	0.000000	0.000000	17,325,881	73.00
76.00	03020	CARDIOLOGY	0	11,649,672	0.000000	0.000000	748,001	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	1,350,811	0.000000	0.000000	48,338	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	3,904,592	0.000000	0.000000	3,158	90.50
91.00	09100	EMERGENCY	371,984	43,677,970	0.008517	0.008517	2,848,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	371,984	956,259,366			78,202,975	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
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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)	Hospital	PPS
Title XIX						
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	0	0		66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	0	0		66.10
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0		67.10
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	0	0		68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 CARDIOLOGY	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0		90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0		90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	0	0		90.50
91.00	09100 EMERGENCY	24,257	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	24,257	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 9:20 am
		Component CCN: 15S058	Title XIX	Subprovider - IPF
				PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,921,849	109,294,565	0.035883	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,418,594	19,936,778	0.071155	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,363,648	102,796,038	0.022994	1,347	31 54.00
57.00	05700	CT SCAN	121,172	54,360,455	0.002229	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,299	1,539,204	0.103494	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	649,560	44,990,922	0.014438	0	0 59.00
60.00	06000	LABORATORY	554,780	102,390,600	0.005418	13,546	73 60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	407,767	37,835,922	0.010777	0	0 65.00
66.00	06600	PHYSICAL THERAPY	496,037	12,004,781	0.041320	8,395	347 66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	15,200	4,523,020	0.003361	0	0 66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	4,322	1,274,346	0.003392	0	0 66.10
67.00	06700	OCCUPATIONAL THERAPY	302,875	6,268,614	0.048316	4,629	224 67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	2,842	889,626	0.003195	0	0 67.10
68.00	06800	SPEECH PATHOLOGY	29,597	4,022,446	0.007358	0	0 68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	2,154	791,911	0.002720	0	0 68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,222,687	75,114,702	0.016278	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	280,585	153,085,382	0.001833	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	651,938	148,349,610	0.004395	40,583	178 73.00
76.00	03020	CARDIOLOGY	314,755	11,649,672	0.027018	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0 90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0 90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	361,769	1,350,811	0.267816	0	0 90.30
90.50	09004	SLEEP DISORDERS CLINIC	9,272	3,904,592	0.002375	0	0 90.50
91.00	09100	EMERGENCY	1,526,941	43,677,970	0.034959	2,519	88 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0	0 92.00
200.00		Total (lines 50-199)	14,817,643	956,259,366		71,019	941 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
	Component CCN: 15S058	Title XIX	Subprovider - IPF PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 CARDIOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	0	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	0	0	90.50
91.00 09100 EMERGENCY	0	0	371,984	0	371,984	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	371,984	0	371,984	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058 Component CCN: 15S058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
	Title XIX	Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	109,294,565	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	19,936,778	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	102,796,038	0.000000	0.000000	1,347	54.00
57.00	05700 CT SCAN	0	54,360,455	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,539,204	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	44,990,922	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	102,390,600	0.000000	0.000000	13,546	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	37,835,922	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	12,004,781	0.000000	0.000000	8,395	66.00
66.01	06602 PHYSICAL THERAPY EAST BANK	0	4,523,020	0.000000	0.000000	0	66.01
66.10	06601 PHYSICAL THERAPY LIVING CENTER	0	1,274,346	0.000000	0.000000	0	66.10
67.00	06700 OCCUPATIONAL THERAPY	0	6,268,614	0.000000	0.000000	4,629	67.00
67.10	06701 OCCUPATIONAL THERAPY LIVING CENTER	0	889,626	0.000000	0.000000	0	67.10
68.00	06800 SPEECH PATHOLOGY	0	4,022,446	0.000000	0.000000	0	68.00
68.10	06801 SPEECH THERAPY LIVING CENTER	0	791,911	0.000000	0.000000	0	68.10
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,114,702	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	153,085,382	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	148,349,610	0.000000	0.000000	40,583	73.00
76.00	03020 CARDIOLOGY	0	11,649,672	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.10	09001 FAMILY PRACTICE CLINIC	0	0	0.000000	0.000000	0	90.10
90.30	09002 HEMATOLOGY ONCOLOGY CLINIC	0	1,350,811	0.000000	0.000000	0	90.30
90.50	09004 SLEEP DISORDERS CLINIC	0	3,904,592	0.000000	0.000000	0	90.50
91.00	09100 EMERGENCY	371,984	43,677,970	0.008517	0.008517	2,519	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	371,984	956,259,366			71,019	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
	Component CCN: 15S058	Title XIX	Subprovider - IPF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03020 RADIOLOGY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	90.50
91.00 09100 EMERGENCY	21	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	21	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 9:20 am		
				Component CCN: 15T058		Title XIX		
				Subprovider - IRF		PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,921,849	109,294,565	0.035883	41,219	1,479	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,418,594	19,936,778	0.071155	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,363,648	102,796,038	0.022994	53,642	1,233	54.00
57.00	05700	CT SCAN	121,172	54,360,455	0.002229	36,805	82	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	159,299	1,539,204	0.103494	3,730	386	58.00
59.00	05900	CARDIAC CATHETERIZATION	649,560	44,990,922	0.014438	0	0	59.00
60.00	06000	LABORATORY	554,780	102,390,600	0.005418	102,712	556	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	407,767	37,835,922	0.010777	3,101	33	65.00
66.00	06600	PHYSICAL THERAPY	496,037	12,004,781	0.041320	358,584	14,817	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	15,200	4,523,020	0.003361	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	4,322	1,274,346	0.003392	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	302,875	6,268,614	0.048316	321,466	15,532	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	2,842	889,626	0.003195	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	29,597	4,022,446	0.007358	219,751	1,617	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	2,154	791,911	0.002720	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,222,687	75,114,702	0.016278	65,090	1,060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	280,585	153,085,382	0.001833	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	651,938	148,349,610	0.004395	502,113	2,207	73.00
76.00	03020	CARDIOLOGY	314,755	11,649,672	0.027018	4,806	130	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	361,769	1,350,811	0.267816	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	9,272	3,904,592	0.002375	0	0	90.50
91.00	09100	EMERGENCY	1,526,941	43,677,970	0.034959	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0	0	92.00
200.00		Total (lines 50-199)	14,817,643	956,259,366		1,713,019	39,132	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058 Component CCN: 15T058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
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
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	0	0	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	0	0	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	0	0	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CARDIOLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	0	0	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	0	0	0	90.50
91.00	09100	EMERGENCY	0	0	371,984	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	371,984	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150058 Component CCN: 15T058		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am		
				Title XIX		Subprovider - IRF	PPS	
Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	109,294,565	0.000000	0.000000	41,219	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,936,778	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	102,796,038	0.000000	0.000000	53,642	54.00
57.00	05700	CT SCAN	0	54,360,455	0.000000	0.000000	36,805	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,539,204	0.000000	0.000000	3,730	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	44,990,922	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	102,390,600	0.000000	0.000000	102,712	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	37,835,922	0.000000	0.000000	3,101	65.00
66.00	06600	PHYSICAL THERAPY	0	12,004,781	0.000000	0.000000	358,584	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0	4,523,020	0.000000	0.000000	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0	1,274,346	0.000000	0.000000	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0	6,268,614	0.000000	0.000000	321,466	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0	889,626	0.000000	0.000000	0	67.10
68.00	06800	SPEECH PATHOLOGY	0	4,022,446	0.000000	0.000000	219,751	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0	791,911	0.000000	0.000000	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75,114,702	0.000000	0.000000	65,090	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	153,085,382	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	148,349,610	0.000000	0.000000	502,113	73.00
76.00	03020	CARDIOLOGY	0	11,649,672	0.000000	0.000000	4,806	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0	0	0.000000	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	0	1,350,811	0.000000	0.000000	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0	3,904,592	0.000000	0.000000	0	90.50
91.00	09100	EMERGENCY	371,984	43,677,970	0.008517	0.008517	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	16,207,399	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	371,984	956,259,366			1,713,019	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150058 Component CCN: 15T058	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:20 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
66.01 06602 PHYSICAL THERAPY EAST BANK	0	0	0	66.01
66.10 06601 PHYSICAL THERAPY LIVING CENTER	0	0	0	66.10
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
67.10 06701 OCCUPATIONAL THERAPY LIVING CENTER	0	0	0	67.10
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
68.10 06801 SPEECH THERAPY LIVING CENTER	0	0	0	68.10
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03020 RADIOLOGY	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.10 09001 FAMILY PRACTICE CLINIC	0	0	0	90.10
90.30 09002 HEMATOLOGY ONCOLOGY CLINIC	0	0	0	90.30
90.50 09004 SLEEP DISORDERS CLINIC	0	0	0	90.50
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2015 9:20 am
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)		84,081	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		84,081	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.		44,365	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		31,646	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)		24,387	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)		74,887,763	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)		74,887,763	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		191,029,679	28.00
29.00	Private room charges (excluding swing-bed charges)		130,491,049	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		60,538,630	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.392022	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		2,941.31	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,912.99	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		1,028.32	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		403.12	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		17,884,419	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		57,003,344	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)		890.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		21,720,525	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)		21,720,525	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 9:20 am	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	11,868,509	7,156	1,658.54	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	9,151,060	7,978	1,147.04	0	43.01
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)				42,453,544	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				64,174,069	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)				3,213,533	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				2,433,065	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				5,646,598	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				58,527,471	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)				8,070	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				890.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				7,187,626	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:20 am	
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	9,823,812	74,887,763	0.131180	7,187,626	942,873	90.00
91.00	Nursing School cost	0	74,887,763	0.000000	7,187,626	0	91.00
92.00	Allied health cost	0	74,887,763	0.000000	7,187,626	0	92.00
93.00	All other Medical Education	0	74,887,763	0.000000	7,187,626	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 15S058		Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,041	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,041	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,041	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)		3,418	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)		4,084,928	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)		4,084,928	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)		4,084,928	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)		810.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,769,742	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,769,742	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 15S058				Date/Time Prepared: 5/29/2015 9:20 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01	
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							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					559,311	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,329,053	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)					366,888	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					29,519	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					396,407	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,932,646	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058 Component CCN: 15S058		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:20 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	541,120	4,084,928	0.132467	0	0	90.00
91.00	Nursing School cost	0	4,084,928	0.000000	0	0	91.00
92.00	Allied health cost	0	4,084,928	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,084,928	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 15T058		Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,212	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,212	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)		4,212	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)		1,424	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)		3,716,843	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)		3,716,843	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)		3,716,843	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)		882.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,256,595	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,256,595	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
					Component CCN: 15T058		Date/Time Prepared: 5/29/2015 9:20 am
					Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.01
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)					919,228		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,175,823		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)					178,085		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					67,630		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					245,715		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,930,108		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058 Component CCN: 15T058		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:20 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	526,755	3,716,843	0.141721	0	0	90.00
91.00	Nursing School cost	0	3,716,843	0.000000	0	0	91.00
92.00	Allied health cost	0	3,716,843	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,716,843	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2015 9:20 am
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)		84,081	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		84,081	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)		76,011	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)		11,784	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)		4,725	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)		74,887,763	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)		74,887,763	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)		74,887,763	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)		890.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,495,537	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		10,495,537	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 9:20 am
				Title XIX	Hospital	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	2,348,558	4,725	497.05	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	11,868,509	7,156	1,658.54	0	0	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	9,151,060	7,978	1,147.04	0	0	43.01
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)					19,841,010	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					30,336,547	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,376,843	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,802,737	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,179,580	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					27,156,967	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)					8,070	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					890.66	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					7,187,626	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:20 am	
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	9,823,812	74,887,763	0.131180	7,187,626	942,873	90.00
91.00	Nursing School cost	0	74,887,763	0.000000	7,187,626	0	91.00
92.00	Allied health cost	0	74,887,763	0.000000	7,187,626	0	92.00
93.00	All other Medical Education	0	74,887,763	0.000000	7,187,626	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 15S058		Date/Time Prepared: 5/29/2015 9:20 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,041	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,041	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,041	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)		1,431	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)		4,725	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)		4,084,928	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)		4,084,928	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)		4,084,928	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)		810.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,159,597	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,159,597	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
					Component CCN: 15S058		Date/Time Prepared: 5/29/2015 9:20 am
					Title XIX	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.01
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							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					18,324		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,177,921		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)					153,604		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					962		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					154,566		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,023,355		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058 Component CCN: 15S058		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:20 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	541,120	4,084,928	0.132467	0	0	90.00
91.00	Nursing School cost	0	4,084,928	0.000000	0	0	91.00
92.00	Allied health cost	0	4,084,928	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,084,928	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 15T058		Date/Time Prepared: 5/29/2015 9:20 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,212	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,212	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)		4,212	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)		625	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)		4,725	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)		3,716,843	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)		3,716,843	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)		3,716,843	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)		882.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		551,525	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)		551,525	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
					Component CCN: 15T058		Date/Time Prepared: 5/29/2015 9:20 am
					Title XIX	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
43.01 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.01
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)					538,288		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,089,813		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)					78,163		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					39,132		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					117,295		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					972,518		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150058 Component CCN: 15T058		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:20 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	526,755	3,716,843	0.141721	0	0	90.00
91.00	Nursing School cost	0	3,716,843	0.000000	0	0	91.00
92.00	Allied health cost	0	3,716,843	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,716,843	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/29/2015 9:20 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		59,015,606	30.00
31.00	03100	INTENSIVE CARE UNIT		8,414,243	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - I RF		51,523	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.308864	19,628,039	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482838	121,738	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203985	12,292,679	54.00
57.00	05700	CT SCAN	0.040015	5,953,075	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.614195	635,996	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079738	4,674,303	59.00
60.00	06000	LABORATORY	0.152589	23,190,095	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.143042	9,635,955	65.00
66.00	06600	PHYSICAL THERAPY	0.440394	2,457,658	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.346268	1,620	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.352323	1,683	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.415990	1,047,678	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.328546	518	67.10
68.00	06800	SPEECH PATHOLOGY	0.322824	369,821	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283010	128	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270146	22,466,551	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245517	38,833,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224692	29,702,828	73.00
76.00	03020	CARDIOLOGY	0.362665	2,658,915	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.357438	14	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.251808	0	90.50
91.00	09100	EMERGENCY	0.492328	6,145,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443478	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		179,818,584	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)		179,818,584	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3	
		Component CCN: 15S058		Date/Time Prepared: 5/29/2015 9:20 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
40.00	04000	SUBPROVIDER - IPF		3,325,945	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.308864	96,832	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482838	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203985	32,464	54.00
57.00	05700	CT SCAN	0.040015	14,521	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.614195	1,066	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079738	0	59.00
60.00	06000	LABORATORY	0.152589	304,614	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.143042	5,837	65.00
66.00	06600	PHYSICAL THERAPY	0.440394	261,258	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.346268	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.352323	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.415990	120,724	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.328546	0	67.10
68.00	06800	SPEECH PATHOLOGY	0.322824	2,258	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283010	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270146	42,976	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245517	4,875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224692	1,294,661	73.00
76.00	03020	CARDIOLOGY	0.362665	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.357438	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.251808	0	90.50
91.00	09100	EMERGENCY	0.492328	9,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443478	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,191,261	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)		2,191,261	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3	
		Component CCN: 15T058		Date/Time Prepared: 5/29/2015 9:20 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - IRF		3,296,480	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.308864	12,719	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482838	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203985	107,370	54.00
57.00	05700	CT SCAN	0.040015	56,890	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.614195	7,885	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079738	0	59.00
60.00	06000	LABORATORY	0.152589	258,080	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.143042	112,703	65.00
66.00	06600	PHYSICAL THERAPY	0.440394	595,171	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.346268	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.352323	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.415990	584,174	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.328546	0	67.10
68.00	06800	SPEECH PATHOLOGY	0.322824	338,093	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283010	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270146	125,137	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245517	8,385	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224692	783,584	73.00
76.00	03020	CARDIOLOGY	0.362665	11,315	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.357438	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.251808	0	90.50
91.00	09100	EMERGENCY	0.492328	972	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443478	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,002,478	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)		3,002,478	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/29/2015 9:20 am	
Cost Center Description		Title XIX	Hospital	PPS	
		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		28,395,864	30.00
31.00	03100	INTENSIVE CARE UNIT		7,629,190	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		15,249,178	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
43.00	04300	NURSERY		2,186,781	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.308864	11,027,857	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482838	10,625,363	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203985	5,625,865	54.00
57.00	05700	CT SCAN	0.040015	2,529,357	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.614195	205,128	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079738	1,375,372	59.00
60.00	06000	LABORATORY	0.152589	13,463,212	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.143042	10,951,926	65.00
66.00	06600	PHYSICAL THERAPY	0.440394	665,970	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.346268	352	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.352323	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.415990	394,711	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.328546	0	67.10
68.00	06800	SPEECH PATHOLOGY	0.322824	194,925	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283010	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270146	169,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245517	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224692	17,325,881	73.00
76.00	03020	CARDIOLOGY	0.362665	748,001	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.357438	48,338	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.251808	3,158	90.50
91.00	09100	EMERGENCY	0.492328	2,848,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443478	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		78,202,975	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)		78,202,975	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3	
		Component CCN: 15S058		Date/Time Prepared: 5/29/2015 9:20 am	
		Title XIX	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
40.00	04000	SUBPROVIDER - IPF		107,230	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.308864	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482838	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203985	1,347	54.00
57.00	05700	CT SCAN	0.040015	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.614195	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079738	0	59.00
60.00	06000	LABORATORY	0.152589	13,546	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.143042	0	65.00
66.00	06600	PHYSICAL THERAPY	0.440394	8,395	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.346268	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.352323	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.415990	4,629	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.328546	0	67.10
68.00	06800	SPEECH PATHOLOGY	0.322824	0	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283010	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270146	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245517	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224692	40,583	73.00
76.00	03020	CARDIOLOGY	0.362665	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.357438	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.251808	0	90.50
91.00	09100	EMERGENCY	0.492328	2,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443478	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		71,019	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)		71,019	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3	
		Component CCN: 15T058		Date/Time Prepared: 5/29/2015 9:20 am	
		Title XIX	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
31.01	02060	NEONATAL INTENSIVE CARE UNIT		0	31.01
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - IRF		1,917,284	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.308864	41,219	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.482838	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.203985	53,642	54.00
57.00	05700	CT SCAN	0.040015	36,805	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.614195	3,730	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.079738	0	59.00
60.00	06000	LABORATORY	0.152589	102,712	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.143042	3,101	65.00
66.00	06600	PHYSICAL THERAPY	0.440394	358,584	66.00
66.01	06602	PHYSICAL THERAPY EAST BANK	0.346268	0	66.01
66.10	06601	PHYSICAL THERAPY LIVING CENTER	0.352323	0	66.10
67.00	06700	OCCUPATIONAL THERAPY	0.415990	321,466	67.00
67.10	06701	OCCUPATIONAL THERAPY LIVING CENTER	0.328546	0	67.10
68.00	06800	SPEECH PATHOLOGY	0.322824	219,751	68.00
68.10	06801	SPEECH THERAPY LIVING CENTER	0.283010	0	68.10
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270146	65,090	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.245517	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224692	502,113	73.00
76.00	03020	CARDIOLOGY	0.362665	4,806	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.10	09001	FAMILY PRACTICE CLINIC	0.000000	0	90.10
90.30	09002	HEMATOLOGY ONCOLOGY CLINIC	1.357438	0	90.30
90.50	09004	SLEEP DISORDERS CLINIC	0.251808	0	90.50
91.00	09100	EMERGENCY	0.492328	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.443478	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,713,019	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,713,019	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 9:20 am
		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)		33,970,544	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,339,293	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		1,934,596	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		15,542,236	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		378.89	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)		16.76	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.		3.00	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)		19.76	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		27.17	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)		19.76	12.00
13.00	Total allowable FTE count for the prior year.		19.76	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.		18.26	14.00
15.00	Sum of lines 12 through 14 divided by 3.		19.26	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		19.26	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.050833	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.044966	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.044966	21.00
22.00	IME payment adjustment (see instructions)		1,476,515	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)		7.41	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)		1,476,515	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)		6.54	30.00
31.00	Percentage of Medicaid patient days (see instructions)		31.21	31.00
32.00	Sum of lines 30 and 31		37.75	32.00
33.00	Allowable disproportionate share percentage (see instructions)		20.36	33.00
34.00	Disproportionate share adjustment (see instructions)		2,306,271	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 9:20 am	
		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	7,647,640,435	35.00
35.01	Factor 3 (see instructions)		0.000749360	0.000952703	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		6,778,997	7,285,932	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		5,070,317	1,836,456	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		6,906,773		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)		57,933,992		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)		57,933,992		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,208,066		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).		857,093		52.00
53.00	Nursing and Allied Health Managed Care payment		190,394		53.00
54.00	Special add-on payments for new technologies		18,034		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)		52,340		58.00
59.00	Total (sum of amounts on lines 49 through 58)		63,259,919		59.00
60.00	Primary payer payments		129,183		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		63,130,736		61.00
62.00	Deductibles billed to program beneficiaries		4,753,824		62.00
63.00	Coinurance billed to program beneficiaries		172,928		63.00
64.00	Allowable bad debts (see instructions)		323,516		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		210,285		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		323,516		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		58,414,269		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	MSP PASS THRU RECONCILIATION		-32		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)		-56,611		70.93
70.94	HRR adjustment amount (see instructions)		-1,134		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 9:20 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		58,356,492		71.00
71.01	Sequestration adjustment (see instructions)		1,167,130		71.01
72.00	Interim payments		57,039,115		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)		150,247		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)		16,787,626		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)		0.999622	0.999	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)		1.0000	0.9999	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		16,201	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		24,983,337	2.00
3.00	PPS payments		21,426,977	3.00
4.00	Outlier payment (see instructions)		177,046	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		55,692	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		16,201	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		68,456	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)		68,456	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)		68,456	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		52,255	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)		16,201	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)		21,659,715	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		12,104	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,148,530	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)		17,515,282	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		308,719	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)		17,824,001	30.00
31.00	Primary payer payments		5,911	31.00
32.00	Subtotal (line 30 minus line 31)		17,818,090	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)		582,853	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		378,854	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		582,853	36.00
37.00	Subtotal (see instructions)		18,196,944	37.00
38.00	MSP-LCC reconciliation amount from PS&R		273	38.00
39.00	OTHER ADJUSTMENTS PER PS&R		-429	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)		18,196,242	40.00
40.01	Sequestration adjustment (see instructions)		363,925	40.01
41.00	Interim payments		17,901,620	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-69,303	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: 150058

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2015 9:20 am

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		56,639,515		17,713,320	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	07/17/2014	399,600	07/17/2014	188,300	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		399,600		188,300	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)		57,039,115		17,901,620	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		150,247		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		69,303	6.02
7.00	Total Medicare program liability (see instructions)		57,189,362		17,832,317	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150058
Component CCN: 15S058

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2015 9:20 am
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,601,443		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,601,443		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		90		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,601,533		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150058
Component CCN: 15T058

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2015 9:20 am

Title XVIII

Subprovider -
IRF

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					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		1,749,227		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,749,227		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		22,168		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,771,395		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150058

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

Worksheet E-1
Part II
Date/Time Prepared:
5/29/2015 9:20 am

		Title XVII	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			18,568 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			27,442 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			8,634 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			91,145 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1,182,949,103 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			21,177,615 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)			1,104,986 8.00
9.00	Sequestration adjustment amount (see instructions)			22,100 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,082,886 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,146,983 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)			-64,097 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150058 Component CCN: 15S058	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,876,228 1.00
2.00	Net IPF PPS Outlier Payments			1,713 2.00
3.00	Net IPF PPS ECT Payments			12,788 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			13.810959 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,890,729 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,890,729 16.00
17.00	Primary payer payments			5,509 17.00
18.00	Subtotal (line 16 less line 17).			2,885,220 18.00
19.00	Deductibles			218,816 19.00
20.00	Subtotal (line 18 minus line 19)			2,666,404 20.00
21.00	Coinsurance			11,856 21.00
22.00	Subtotal (line 20 minus line 21)			2,654,548 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,654,548 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			78 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,654,626 31.00
31.01	Sequestration adjustment (see instructions)			53,093 31.01
32.00	Interim payments			2,601,443 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			90 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			1,713 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150058 Component CCN: 15T058	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1,423,343 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0381 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			108,459 3.00
4.00	Outlier Payments			291,240 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			11.539726 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			1,823,042 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,823,042 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,823,042 19.00
20.00	Deductibles			0 20.00
21.00	Subtotal (line 19 minus line 20)			1,823,042 21.00
22.00	Coinsurance			15,504 22.00
23.00	Subtotal (line 21 minus line 22)			1,807,538 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,807,538 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			8 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			1,807,546 32.00
32.01	Sequestration adjustment (see instructions)			36,151 32.01
33.00	Interim payments			1,749,227 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34			22,168 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			2,753,739 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			291,240 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/29/2015 9:20 am	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			24.76	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			3.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			27.76	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			27.17	6.00
7.00	Enter the lesser of line 5 or line 6			27.17	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	27.17	0.00	27.17	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	27.17	0.00	27.17	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	27.17	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	25.02	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	23.92	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	25.37	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	25.37	0.00		17.00
18.00	Per resident amount	116,765.35	0.00		18.00
19.00	Approved amount for resident costs	2,962,337	0	2,962,337	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			2,962,337	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	32,284	8,634		26.00
27.00	Total Inpatient Days (see instructions)	100,873	100,873		27.00
28.00	Ratio of inpatient days to total inpatient days	0.320046	0.085593		28.00
29.00	Program direct GME amount	948,084	253,555		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		35,827		30.00
31.00	Net Program direct GME amount			1,165,812	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		69,678,945	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		134,692	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		69,544,253	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		25,055,230	42.00
43.00	Primary payer payments (see instructions)		5,911	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		25,049,319	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		94,593,572	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.735190	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.264810	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		1,165,812	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		857,093	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		308,719	50.00

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

Provider CCN: 150058

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

Worksheet G

Date/Time Prepared:
5/29/2015 9:20 am

		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	28,348,000	0	0	0	1.00
2.00	Temporary investments	51,005,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	99,561,000	0	0	0	4.00
5.00	Other receivable	21,189,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-20,022,000	0	0	0	6.00
7.00	Inventory	14,162,000	0	0	0	7.00
8.00	Prepaid expenses	1,559,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	9,128,000	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	195,802,000	9,128,000	0	0	11.00
FIXED ASSETS						
12.00	Land	21,923,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	399,389,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	273,487,000	0	0	0	23.00
24.00	Accumulated depreciation	-367,487,000	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)	327,312,000	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	21,756,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	21,756,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	544,870,000	9,128,000	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	51,595,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,107,000	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	5,900,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	63,602,000	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	204,653,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	204,653,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	268,255,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	276,615,000	0	0	0	52.00
53.00	Specific purpose fund	0	9,128,000	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	276,615,000	9,128,000	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	544,870,000	9,128,000	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150058

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

Worksheet G-1

Date/Time Prepared:
5/29/2015 9:20 am

		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		618,652,000		6,484,000		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		96,872,000				2.00
3.00	Total (sum of line 1 and line 2)		715,524,000		6,484,000		3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION	387,000		0		0	4.00
5.00	CAPITAL CONTRIBUTIONS	0		2,644,000		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		387,000		2,644,000		10.00
11.00	Subtotal (line 3 plus line 10)		715,911,000		9,128,000		11.00
12.00	TRANSFERRED TO BEACON HEALTH SYSTEM	439,296,000		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		439,296,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		276,615,000		9,128,000		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	NET ASSETS RELEASED FROM RESTRICTION		0				4.00
5.00	CAPITAL CONTRIBUTIONS		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	TRANSFERRED TO BEACON HEALTH SYSTEM		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: 150058

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2015 9:20 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	185,784,289		185,784,289	1.00
2.00	SUBPROVIDER - IPF	4,956,982		4,956,982	2.00
3.00	SUBPROVIDER - IRF	9,845,650		9,845,650	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	200,586,921		200,586,921	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	33,007,380		33,007,380	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	23,571,599		23,571,599	11.01
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)	56,578,979		56,578,979	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	257,165,900		257,165,900	17.00
18.00	Ancillary services	532,400,928	0	532,400,928	18.00
19.00	Outpatient services	0	448,478,672	448,478,672	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	789,566,828	448,478,672	1,238,045,500	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		407,968,343		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)		407,968,343		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150058

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

Worksheet G-3

Date/Time Prepared:
5/29/2015 9:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,238,045,500	1.00
2.00	Less contractual allowances and discounts on patients' accounts	777,373,511	2.00
3.00	Net patient revenues (line 1 minus line 2)	460,671,989	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	407,968,343	4.00
5.00	Net income from service to patients (line 3 minus line 4)	52,703,646	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	9,455,000	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	1,090,602	11.00
12.00	Parking lot receipts	214,507	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,368,248	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	1,789,888	23.00
24.00	MISC OTHER REVENUE	30,250,109	24.00
25.00	Total other income (sum of lines 6-24)	44,168,354	25.00
26.00	Total (line 5 plus line 25)	96,872,000	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	96,872,000	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150058	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/29/2015 9:20 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,600,842	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		243,899	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)		254.92	3.00
4.00	Number of interns & residents (see instructions)		19.26	4.00
5.00	Indirect medical education percentage (see instructions)		2.15	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		77,418	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		6.54	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		31.21	8.00
9.00	Sum of lines 7 and 8		37.75	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.94	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		285,907	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		4,208,066	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