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: 150146

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/22/2015 1:36 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2015 Time: 1:36 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPT. OF NOBLE CTY, INC. (150146) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	12,055	-25,204	-2,865	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	12,055	-25,204	-2,865	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: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2015 1:05 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 401 SAWYER ROAD	PO Box: 728			1.00
2.00	City: KENDALLVILLE	State: IN	Zip Code: 46755-0728	County: NOBLE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	COMMUNITY HOSPT. OF NOBLE CTY, INC.	150146	21140	1	05/30/2000	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	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.	382	39	0	0	734	42	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2015 1:05 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		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.	2	10/01/2013	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	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)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2015 1:05 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2015 1:05 pm

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

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

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

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

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		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N				109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	49,709	187,521	22,390	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.	Y		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	Y	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: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/22/2015 1:05 pm

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H032	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: PARKVIEW HEALTH SYSTEM, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 08101	141.00
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600		142.00
143.00	City: FORT WAYNE	State: IN	Zip Code: 46845	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/22/2015 1:05 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	170.00

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2015 1:05 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/30/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		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: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/22/2015 1:05 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC	NICKESON	41.00
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALTH SYSTEM, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	260-373-8406	ERIC.NICKESON@PARKVIEW.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/22/2015 1:05 pm

		Part B Date		
		4.00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/30/2013		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.	DIRECTOR REIMBURSEMENT		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: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2015 1:05 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	31	11,315	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)		31	11,315	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		31	11,315	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		31				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2015 1:05 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,133	306	5,579			1.00
2.00	HMO and other (see instructions)	1,520	773				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,133	306	5,579			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		76	555			13.00
14.00	Total (see instructions)	2,133	382	6,134	0.00	211.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	211.00	27.00
28.00	Observation Bed Days		186	1,272			28.00
29.00	Ambulance Trips	1,525					29.00
30.00	Employee discount days (see instruction)			71			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	42	71			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: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2015 1:05 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	578	383	1,632	1.00
2.00	HMO and other (see instructions)			362	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	578	383	1,632	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2015 1:05 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	13,192,087	3,585,915	16,778,002	485,023.00	34.59	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		51,338	0	51,338	490.00	104.77	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		4,550,428	0	4,550,428	132,479.00	34.35	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,707,183	171,880	1,879,063	87,562.00	21.46	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		4,550,428	0	4,550,428	132,479.00	34.35	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)		4,603,954	0	4,603,954			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		751,948	0	751,948			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		51,338	0	51,338			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,953,743	-1,953,743	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	705,917	4,511,575	5,217,492	153,415.00	34.01	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	324,422	31,968	356,390	17,271.00	20.64	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	262,324	25,849	288,173	23,642.00	12.19	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	333,141	-100,636	232,505	16,079.00	14.46	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	131,014	131,014	10,811.00	12.12	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	407,110	40,116	447,226	14,108.00	31.70	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	517,577	51,001	568,578	12,271.00	46.34	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/22/2015 1:05 pm

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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/22/2015 1:05 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		8,641,659	3,585,915	12,227,574	352,544.00	34.68	1.00
2.00	Excluded area salaries (see instructions)		1,707,183	171,880	1,879,063	87,562.00	21.46	2.00
3.00	Subtotal salaries (line 1 minus line 2)		6,934,476	3,414,035	10,348,511	264,982.00	39.05	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,550,428	0	4,550,428	132,479.00	34.35	4.00
5.00	Subtotal wage-related costs (see inst.)		4,655,292	0	4,655,292	0.00	44.99	5.00
6.00	Total (sum of lines 3 thru 5)		16,140,196	3,414,035	19,554,231	397,461.00	49.20	6.00
7.00	Total overhead cost (see instructions)		4,504,234	2,737,144	7,241,378	247,597.00	29.25	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/22/2015 1:05 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	322,386	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	573,600	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	55,496	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,953,303	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	25,762	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)	54,245	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	86,904	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	1,222,669	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	29,390	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	32,147	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,355,902	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: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 5/22/2015 1:05 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 Date/Time Prepared: 5/22/2015 1:05 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.224289	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,817,609	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	1,184,566	5.00
6.00	Medicaid charges	19,121,828	6.00
7.00	Medicaid cost (line 1 times line 6)	4,288,816	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,286,641	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	314,804	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	2,470,579	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	554,124	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)	239,320	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	9,359	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,525,961	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	1,279,331	791,885	2,071,216	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	286,940	177,611	464,551	21.00
22.00	Partial payment by patients approved for charity care	1,771	16,707	18,478	22.00
23.00	Cost of charity care (line 21 minus line 22)	285,169	160,904	446,073	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	9,128,000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	33,466	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	9,094,534	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,039,804	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,485,877	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,011,838	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,116,475	2,116,475	-446,669	1,669,806	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	608,885	608,885	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,953,743	4,129,967	6,083,710	-1,953,743	4,129,967	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	705,917	13,270,455	13,976,372	793,748	14,770,120	5.00
7.00	00700	OPERATION OF PLANT	324,422	996,961	1,321,383	30,572	1,351,955	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	155,319	155,319	8.00
9.00	00900	HOUSEKEEPING	262,324	280,110	542,434	-129,862	412,572	9.00
10.00	01000	DIETARY	333,141	191,606	524,747	-196,155	328,592	10.00
11.00	01100	CAFETERIA	0	4,177	4,177	224,236	228,413	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	407,110	5,459	412,569	39,765	452,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	517,577	72,313	589,890	50,648	640,538	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,269,537	386,936	2,656,473	-321,193	2,335,280	30.00
43.00	04300	NURSERY	0	0	0	84,228	84,228	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	894,689	385,030	1,279,719	11,751	1,291,470	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	444,585	444,585	52.00
53.00	05300	ANESTHESIOLOGY	0	948,288	948,288	0	948,288	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,260,075	686,033	1,946,108	35,455	1,981,563	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	1,749,097	1,749,097	-2,493	1,746,604	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	469,639	78,351	547,990	43,059	591,049	65.00
66.00	06600	PHYSICAL THERAPY	987,088	195,068	1,182,156	-453,329	728,827	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,000	1,000	377,081	378,081	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	135,803	135,803	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,002	10,002	0	10,002	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	733,675	733,675	-326,303	407,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	324,079	324,079	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,915,021	1,915,021	-16,026	1,898,995	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,133	3,305	26,438	4,729	31,167	90.00
91.00	09100	EMERGENCY	1,076,509	218,179	1,294,688	-16,606	1,278,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,577,813	295,257	1,873,070	152,837	2,025,907	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,062,717	28,672,765	41,735,482	-345,599	41,389,883	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,637	724	24,361	1,986	26,347	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,897	6,255	40,152	1,672	41,824	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	-259,974	-259,974	259,974	0	194.02
194.03	07953	FOUNDATION	0	0	0	80,004	80,004	194.03
194.04	07954	PHYSICIAN OFFICES	1,573	0	1,573	155	1,728	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	70,263	379,170	449,433	1,808	451,241	194.05
194.06	07956	VACANT SPACE	0	2,170	2,170	0	2,170	194.06
200.00		TOTAL (SUM OF LINES 118-199)	13,192,087	28,801,110	41,993,197	0	41,993,197	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,310,127	359,679	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	46,232	655,117	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,609,118	2,520,849	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,556,665	11,213,455	5.00
7.00	00700	OPERATION OF PLANT	-4,502	1,347,453	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	155,319	8.00
9.00	00900	HOUSEKEEPING	-102	412,470	9.00
10.00	01000	DIETARY	-4,171	324,421	10.00
11.00	01100	CAFETERIA	-175,314	53,099	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	452,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-700,859	-60,321	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	14,396	2,349,676	30.00
43.00	04300	NURSERY	0	84,228	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,291,470	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	444,585	52.00
53.00	05300	ANESTHESIOLOGY	-934,857	13,431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-18,173	1,963,390	54.00
54.01	05401	CAT SCAN	0	0	54.01
60.00	06000	LABORATORY	0	1,746,604	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-2,716	588,333	65.00
66.00	06600	PHYSICAL THERAPY	-136,638	592,189	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	378,081	67.00
68.00	06800	SPEECH PATHOLOGY	0	135,803	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,002	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	407,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	324,079	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,898,995	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-289	30,878	90.00
91.00	09100	EMERGENCY	0	1,278,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,810	2,024,097	95.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,394,713	32,995,170	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,347	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	41,824	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	194.01
194.02	07952	OCC HEALTH	0	0	194.02
194.03	07953	FOUNDATION	0	80,004	194.03
194.04	07954	PHYSICIAN OFFICES	0	1,728	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	-137,680	313,561	194.05
194.06	07956	VACANT SPACE	0	2,170	194.06
200.00		TOTAL (SUM OF LINES 118-199)	-8,532,393	33,460,804	200.00

RECLASSIFICATIONS	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet A-6 Date/Time Prepared: 5/22/2015 1:05 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - REHAB THERAPY				
1.00	OCCUPATIONAL THERAPY	67.00	308,598	86,066	1.00
2.00	SPEECH PATHOLOGY	68.00	106,188	29,615	2.00
	0		414,786	115,681	
	C - INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	24,812	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,144	2.00
	0		0	34,956	
	D - EQUIPMENT LEASE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	67,966	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	59,294	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
	0		0	127,260	
	E - DRUGS CHARGED TO PATIENTS				
1.00		0.00	0	0	1.00
	0		0	0	
	F - CLINIC DIETICIAN				
1.00	CLINIC	90.00	2,449	0	1.00
	0		2,449	0	
	G - PTO				
1.00	ADMINISTRATIVE & GENERAL	5.00	925,660	0	1.00
2.00	OPERATION OF PLANT	7.00	31,968	0	2.00
3.00	HOUSEKEEPING	9.00	25,849	0	3.00
4.00	DIETARY	10.00	32,827	0	4.00
5.00	NURSING ADMINISTRATION	13.00	40,116	0	5.00
6.00	PHARMACY	15.00	51,001	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	210,216	0	7.00
8.00	OPERATING ROOM	50.00	88,161	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	124,165	0	9.00
10.00	RESPIRATORY THERAPY	65.00	46,277	0	10.00
11.00	PHYSICAL THERAPY	66.00	97,266	0	11.00
12.00	CLINIC	90.00	2,280	0	12.00
13.00	EMERGENCY	91.00	106,077	0	13.00
14.00	AMBULANCE SERVICES	95.00	155,474	0	14.00
15.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	2,329	0	15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	3,340	0	16.00
17.00	COMMUNITY & VOLUNTEER SERVICES	194.05	10,582	0	17.00
18.00	PHYSICIAN OFFICES	194.04	155	0	18.00
	0		1,953,743	0	
	H - CAFETERIA				
1.00	CAFETERIA	11.00	131,014	93,222	1.00
	0		131,014	93,222	
	I - DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	539,447	1.00
	0		0	539,447	
	J - HOME OFFICE SALARY				
1.00	ADMINISTRATIVE & GENERAL	5.00	3,585,915	0	1.00
	0		3,585,915	0	
	K - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	155,319	1.00
	0		0	155,319	
	L - OCCH HEALTH				
1.00	OCC HEALTH	194.02	0	259,974	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

RECLASSIFICATIONS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/22/2015 1:05 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	0		0	259,974	
	M - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	324,079	1.00
	0		0	324,079	
	N - OB				
1.00	NURSERY	43.00	76,839	7,389	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	405,586	38,999	2.00
	0		482,425	46,388	
	P - OTHER				
1.00	FOUNDATION	194.03	0	80,004	1.00
	0		0	80,004	
500.00	Grand Total: Increases		6,570,332	1,776,330	500.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	B - REHAB THERAPY					
1.00	PHYSICAL THERAPY	66.00	414,786	115,681	9	1.00
2.00		0.00	0	0	0	2.00
	0		414,786	115,681		
	C - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,956	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	34,956		
	D - EQUIPMENT LEASE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,952	10	1.00
2.00	OPERATION OF PLANT	7.00	0	1,396	10	2.00
3.00	HOUSEKEEPING	9.00	0	392	0	3.00
4.00	DIETARY	10.00	0	2,297	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	351	0	5.00
6.00	PHARMACY	15.00	0	353	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	2,596	0	7.00
8.00	OPERATING ROOM	50.00	0	76,139	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,046	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	3,042	0	10.00
11.00	PHYSICAL THERAPY	66.00	0	3,567	0	11.00
12.00	EMERGENCY	91.00	0	3,707	0	12.00
13.00	AMBULANCE SERVICES	95.00	0	2,637	0	13.00
14.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	343	0	14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,668	0	15.00
16.00	COMMUNITY & VOLUNTEER SERVICES	194.05	0	8,774	0	16.00
	0		0	127,260		
	E - DRUGS CHARGED TO PATIENTS					
1.00		0.00	0	0	0	1.00
	0		0	0		
	F - CLINIC DIETICIAN					
1.00	DIETARY	10.00	2,449	0	0	1.00
	0		2,449	0		
	G - PTO					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,953,743	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
	0		1,953,743	0		
	H - CAFETERIA					
1.00	DIETARY	10.00	131,014	93,222	0	1.00
	0		131,014	93,222		
	I - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	539,447	9	1.00
	0		0	539,447		
	J - HOME OFFICE SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,585,915	0	1.00
	0		0	3,585,915		
	K - LAUNDRY					
1.00	HOUSEKEEPING	9.00	0	155,319	0	1.00
	0		0	155,319		
	L - OCCH HEALTH					
1.00	OPERATING ROOM	50.00	0	271	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	85,664	0	2.00
3.00	LABORATORY	60.00	0	2,493	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	176	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	16,561	0	5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	17,583	0	6.00

RECLASSIFICATIONS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/22/2015 1:05 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,224	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,026	0		8.00
9.00	EMERGENCY	91.00	0	118,976	0		9.00
	0		0	259,974			
	M - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	324,079	0		1.00
	0		0	324,079			
	N - OB						
1.00	ADULTS & PEDIATRICS	30.00	482,425	46,388	0		1.00
2.00		0.00	0	0	0		2.00
	0		482,425	46,388			
	P - OTHER						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	80,004	0		1.00
	0		0	80,004			
500.00	Grand Total: Decreases		2,984,417	5,362,245			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I Date/Time Prepared: 5/22/2015 1:05 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	314,996	322,239	0	322,239	0	2.00
3.00	Buildings and Fixtures	2,889,131	219,913	0	219,913	0	3.00
4.00	Building Improvements	57,402	0	0	0	0	4.00
5.00	Fixed Equipment	262,844	13,958	0	13,958	0	5.00
6.00	Movable Equipment	12,395,455	69,231	0	69,231	1,072,845	6.00
7.00	HIT designated Assets	2,291,849	330,679	0	330,679	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,211,677	956,020	0	956,020	1,072,845	8.00
9.00	Reconciling Items	2,117,527	505,001	0	505,001	0	9.00
10.00	Total (line 8 minus line 9)	16,094,150	451,019	0	451,019	1,072,845	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	637,235	89,216	2.00
3.00	Buildings and Fixtures	3,109,044	67,079	3.00
4.00	Building Improvements	57,402	1,000	4.00
5.00	Fixed Equipment	276,802	25,227	5.00
6.00	Movable Equipment	11,391,841	7,560,237	6.00
7.00	HIT designated Assets	2,622,528	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,094,852	7,742,759	8.00
9.00	Reconciling Items	2,622,528	0	9.00
10.00	Total (line 8 minus line 9)	15,472,324	7,742,759	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II Date/Time Prepared: 5/22/2015 1:05 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,116,475	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,116,475	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,116,475	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	2,116,475	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/22/2015 1:05 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	4,080,483	0	4,080,483	0.270708	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,391,842	398,959	10,992,883	0.729292	0	2.00
3.00	Total (sum of lines 1-2)	15,472,325	398,959	15,073,366	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	266,901	67,966	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	585,679	59,294	2.00
3.00	Total (sum of lines 1-2)	0	0	0	852,580	127,260	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	24,812	0	0	359,679	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,144	0	0	655,117	2.00
3.00	Total (sum of lines 1-2)	0	34,956	0	0	1,014,796	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/22/2015 1:05 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-3,965	PHARMACY	15.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-8,527	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,641	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-934,857			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	-344,288			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	A	-51,968	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-50,727	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	47,234	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/22/2015 1:05 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	TELEPHONE	A	-719	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.01
33.02	TELEPHONE	A	-1,282	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	TELEVISION OFFSET - DEPR	A	-283	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.03
33.04	PHYSICIAN RECRUITMENT	A	-25,000	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PHARMACY SALES	B	-68,277	PHARMACY	15.00	0	33.05
33.06	SELF INSURANCE	A	-1,607,836	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	COMMUNITY HEALTH	A	-83,664	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	COMMUNITY HEALTH	A	-3,483	CAFETERIA	11.00	0	33.08
33.09	LOBBY DUES	A	-7,103	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.12	INTERUNIT	A	-125,682	PHYSICAL THERAPY	66.00	9	33.12
33.13	INTERUNIT	A	-2,997,917	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	INTERUNIT	A	-1,259,400	CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.15	INTERUNIT	A	-121,692	COMMUNITY & VOLUNTEER SERVICES	194.05	0	33.15
33.16	INTERUNIT	A	-12,384	RADIOLOGY-DIAGNOSTIC	54.00	0	33.16
33.17	OTHER OPERATING REVENUE	B	-90,166	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	OTHER OPERATING REVENUE	B	-2,861	OPERATION OF PLANT	7.00	0	33.18
33.19	OTHER OPERATING REVENUE	B	-102	HOUSEKEEPING	9.00	0	33.19
33.20	OTHER OPERATING REVENUE	B	-4,171	DIETARY	10.00	0	33.20
33.21	OTHER OPERATING REVENUE	B	-119,863	CAFETERIA	11.00	0	33.21
33.22	OTHER OPERATING REVENUE	B	-628,617	PHARMACY	15.00	0	33.22
33.23	OTHER OPERATING REVENUE	B	-19,450	ADULTS & PEDIATRICS	30.00	0	33.23
33.24	OTHER OPERATING REVENUE	B	-5,789	RADIOLOGY-DIAGNOSTIC	54.00	0	33.24
33.25	OTHER OPERATING REVENUE	B	-2,716	RESPIRATORY THERAPY	65.00	0	33.25
33.26	OTHER OPERATING REVENUE	B	-10,956	PHYSICAL THERAPY	66.00	0	33.26
33.27	OTHER OPERATING REVENUE	B	-289	CLINIC	90.00	0	33.27
33.28	OTHER OPERATING REVENUE	B	-1,810	AMBULANCE SERVICES	95.00	0	33.28
33.29	OTHER OPERATING REVENUE	B	-15,988	COMMUNITY & VOLUNTEER SERVICES	194.05	0	33.29
33.30	TELEMETRY	A	33,846	ADULTS & PEDIATRICS	30.00	0	33.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,532,393				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: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/22/2015 1:05 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	8,244,712	8,589,000	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
3.01	0.00			0	0	3.01
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,244,712	8,589,000	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		
	Symbol (1)	Name	Percentage of Ownership	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	B		0.00	PARKVIEW HEALTH SYSTEM, INC.	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: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/22/2015 1:05 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-344,288	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
3.01	0	0	3.01
4.00	0	0	4.00
5.00	-344,288		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: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 Date/Time Prepared: 5/22/2015 1:05 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	948,242	926,904	21,338	200,300	139	1.00
2.00	91.00	EMERGENCY	30,000	0	30,000	200,300	351	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			978,242	926,904	51,338		490	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	53.00	ANESTHESIOLOGY	13,385	669	0	0	0	1.00
2.00	91.00	EMERGENCY	33,801	1,690	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			47,186	2,359	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	53.00	ANESTHESIOLOGY	0	13,385	7,953	934,857		1.00
2.00	91.00	EMERGENCY	0	33,801	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	47,186	7,953	934,857		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	359,679	359,679				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	655,117		655,117			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,520,849	0	0	2,520,849		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,213,455	92,273	9,678	783,917	12,099,323	5.00
7.00	00700	OPERATION OF PLANT	1,347,453	35,310	79,821	53,547	1,516,131	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	155,319	3,038	0	0	158,357	8.00
9.00	00900	HOUSEKEEPING	412,470	4,394	4,008	43,297	464,169	9.00
10.00	01000	DIETARY	324,421	9,045	6,339	34,933	374,738	10.00
11.00	01100	CAFETERIA	53,099	5,851	0	19,684	78,634	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	452,334	1,230	950	67,194	521,708	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,300	0	0	11,300	14.00
15.00	01500	PHARMACY	-60,321	3,332	85,823	85,427	114,261	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,090	0	0	5,090	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,349,676	52,265	76,237	300,093	2,778,271	30.00
43.00	04300	NURSERY	84,228	764	0	11,545	96,537	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,291,470	39,814	89,686	147,670	1,568,640	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	444,585	4,906	0	60,938	510,429	52.00
53.00	05300	ANESTHESIOLOGY	13,431	0	5,059	0	18,490	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,963,390	23,844	207,718	207,978	2,402,930	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	1,746,604	7,032	0	0	1,753,636	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	588,333	6,048	28,661	77,515	700,557	65.00
66.00	06600	PHYSICAL THERAPY	592,189	2,412	9,521	100,601	704,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	378,081	0	0	46,366	424,447	67.00
68.00	06800	SPEECH PATHOLOGY	135,803	0	0	15,954	151,757	68.00
69.00	06900	ELECTROCARDIOLOGY	10,002	503	0	0	10,505	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	407,372	0	0	0	407,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	324,079	0	0	0	324,079	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,898,995	0	0	0	1,898,995	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	30,878	0	0	4,186	35,064	90.00
91.00	09100	EMERGENCY	1,278,082	22,257	13,635	177,680	1,491,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,024,097	0	34,028	260,421	2,318,546	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,995,170	330,708	651,164	2,498,946	32,940,343	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,347	2,811	2,043	3,901	35,102	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41,824	19,990	1,786	5,595	69,195	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	80,004	0	0	0	80,004	194.03
194.04	07954	PHYSICIAN OFFICES	1,728	5,216	0	260	7,204	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	313,561	954	124	12,147	326,786	194.05
194.06	07956	VACANT SPACE	2,170	0	0	0	2,170	194.06
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)	33,460,804	359,679	655,117	2,520,849	33,460,804	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,099,323					5.00
7.00	00700	OPERATION OF PLANT	858,749	2,374,880				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	89,695	31,082	279,134			8.00
9.00	00900	HOUSEKEEPING	262,909	44,958	11,460	783,496		9.00
10.00	01000	DIETARY	212,255	92,554	398	31,544	711,489	10.00
11.00	01100	CAFETERIA	44,539	59,871	397	20,405	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	295,500	12,590	0	4,291	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,400	115,630	8,450	39,409	0	14.00
15.00	01500	PHARMACY	64,718	34,095	0	11,621	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,883	52,085	0	17,752	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,573,644	534,792	97,380	182,270	711,489	30.00
43.00	04300	NURSERY	54,679	7,817	281	2,664	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	888,490	407,388	73,394	138,847	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	289,111	50,201	282	17,110	0	52.00
53.00	05300	ANESTHESIOLOGY	10,473	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,361,039	243,974	27,820	83,152	0	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	993,273	71,958	691	24,525	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	396,801	61,880	1,704	21,090	0	65.00
66.00	06600	PHYSICAL THERAPY	399,161	24,677	0	8,410	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	240,410	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	85,956	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,950	5,149	0	1,755	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	230,739	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	183,561	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,075,606	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,861	0	0	0	0	90.00
91.00	09100	EMERGENCY	844,885	227,743	53,701	77,620	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,313,243	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,804,530	2,078,444	275,958	682,465	711,489	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,882	28,758	0	9,801	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,193	204,542	3,176	69,712	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	45,315	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	4,080	53,372	0	18,190	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	185,094	9,764	0	3,328	0	194.05
194.06	07956	VACANT SPACE	1,229	0	0	0	0	194.06
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)	12,099,323	2,374,880	279,134	783,496	711,489	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	203,846					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	7,257	0	841,346			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	181,189		14.00
15.00	01500	PHARMACY	6,312	0	0	3,086	234,093	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,416	0	351,527	24,099	228	30.00
43.00	04300	NURSERY	1,593	0	14,577	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,626	0	170,434	23,937	3,313	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,409	0	76,949	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,952	0	0	7,371	35	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	10,440	0	0	6,795	0	65.00
66.00	06600	PHYSICAL THERAPY	9,024	0	0	3,003	12	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,465	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,881	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	77,570	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	3,607	229,172	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	529	0	0	137	0	90.00
91.00	09100	EMERGENCY	24,901	0	227,859	13,652	67	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	39,847	0	0	15,428	1,216	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	198,652	0	841,346	178,685	234,043	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	667	0	0	27	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,177	0	0	328	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	1,111	0	0	0	50	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	2,239	0	0	2,149	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
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)	203,846	0	841,346	181,189	234,093	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	77,810					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,740	0	0	0	0	30.00
43.00	04300	NURSERY	225	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,899	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,277	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,131	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,759	0	0	0	0	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	7,861	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,775	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,361	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	507	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	187	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	280	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,502	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,094	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,213	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18	0	0	0	0	90.00
91.00	09100	EMERGENCY	11,286	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,695	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,810	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	77,810	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	6,296,856	0	6,296,856	30.00
43.00	04300	NURSERY	0	0	178,373	0	178,373	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,300,968	0	3,300,968	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	953,768	0	953,768	52.00
53.00	05300	ANESTHESIOLOGY	0	0	30,094	0	30,094	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,177,032	0	4,177,032	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	2,851,944	0	2,851,944	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	1,202,042	0	1,202,042	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,150,371	0	1,150,371	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	670,829	0	670,829	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	239,781	0	239,781	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	23,639	0	23,639	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	718,183	0	718,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	508,734	0	508,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,213,593	0	3,213,593	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	55,609	0	55,609	90.00
91.00	09100	EMERGENCY	0	0	2,973,368	0	2,973,368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	3,691,975	0	3,691,975	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	32,237,159	0	32,237,159	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	94,237	0	94,237	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	387,323	0	387,323	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	126,480	0	126,480	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	82,846	0	82,846	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	529,360	0	529,360	194.05
194.06	07956	VACANT SPACE	0	0	3,399	0	3,399	194.06
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)	0	0	33,460,804	0	33,460,804	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,013,291	92,273	9,678	2,115,242	0	5.00
7.00	00700	OPERATION OF PLANT	0	35,310	79,821	115,131	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,038	0	3,038	0	8.00
9.00	00900	HOUSEKEEPING	0	4,394	4,008	8,402	0	9.00
10.00	01000	DIETARY	0	9,045	6,339	15,384	0	10.00
11.00	01100	CAFETERIA	0	5,851	0	5,851	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,230	950	2,180	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,300	0	11,300	0	14.00
15.00	01500	PHARMACY	0	3,332	85,823	89,155	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,090	0	5,090	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	52,265	76,237	128,502	0	30.00
43.00	04300	NURSERY	0	764	0	764	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	39,814	89,686	129,500	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,906	0	4,906	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	5,059	5,059	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,844	207,718	231,562	0	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	7,032	0	7,032	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	6,048	28,661	34,709	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,412	9,521	11,933	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	503	0	503	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	22,257	13,635	35,892	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	34,028	34,028	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,013,291	330,708	651,164	2,995,163	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,811	2,043	4,854	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	19,990	1,786	21,776	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	5,216	0	5,216	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	954	124	1,078	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
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)	2,013,291	359,679	655,117	3,028,087	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,115,242					5.00
7.00	00700	OPERATION OF PLANT	150,129	265,260				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,681	3,472	22,191			8.00
9.00	00900	HOUSEKEEPING	45,962	5,022	911	60,297		9.00
10.00	01000	DIETARY	37,107	10,338	32	2,428	65,289	10.00
11.00	01100	CAFETERIA	7,786	6,687	32	1,570	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	51,660	1,406	0	330	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,119	12,915	672	3,033	0	14.00
15.00	01500	PHARMACY	11,314	3,808	0	894	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	504	5,818	0	1,366	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	275,115	59,733	7,741	14,028	65,289	30.00
43.00	04300	NURSERY	9,559	873	22	205	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	155,328	45,503	5,835	10,686	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,543	5,607	22	1,317	0	52.00
53.00	05300	ANESTHESIOLOGY	1,831	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	237,941	27,250	2,212	6,399	0	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	173,647	8,037	55	1,887	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	69,370	6,912	135	1,623	0	65.00
66.00	06600	PHYSICAL THERAPY	69,782	2,756	0	647	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,029	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,027	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,040	575	0	135	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,338	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,091	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	188,040	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,472	0	0	0	0	90.00
91.00	09100	EMERGENCY	147,705	25,438	4,269	5,974	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	229,585	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,063,705	232,150	21,938	52,522	65,289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,476	3,212	0	754	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,852	22,846	253	5,365	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	7,922	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	713	5,961	0	1,400	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	32,359	1,091	0	256	0	194.05
194.06	07956	VACANT SPACE	215	0	0	0	0	194.06
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)	2,115,242	265,260	22,191	60,297	65,289	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	21,926					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	781	0	56,357			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	29,039		14.00
15.00	01500	PHARMACY	679	0	0	495	84,556	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,132	0	23,548	3,862	82	30.00
43.00	04300	NURSERY	171	0	976	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,003	0	11,416	3,836	1,197	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	905	0	5,154	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,791	0	0	1,181	13	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,123	0	0	1,089	0	65.00
66.00	06600	PHYSICAL THERAPY	971	0	0	481	5	66.00
67.00	06700	OCCUPATIONAL THERAPY	588	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	202	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,433	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	578	82,778	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	57	0	0	22	0	90.00
91.00	09100	EMERGENCY	2,678	0	15,263	2,188	24	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,285	0	0	2,473	439	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,366	0	56,357	28,638	84,538	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72	0	0	4	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127	0	0	53	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	120	0	0	0	18	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	241	0	0	344	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	21,789	201.00
202.00		TOTAL (sum lines 118-201)	21,926	0	56,357	29,039	106,345	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
			16.00	17.00	19.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	12,778					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	780	0				30.00
43.00	04300	NURSERY	37	0				43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,299	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	210	0				52.00
53.00	05300	ANESTHESIOLOGY	186	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,051	0				54.00
54.01	05401	CAT SCAN	0	0				54.01
60.00	06000	LABORATORY	1,293	0				60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65.00	06500	RESPIRATORY THERAPY	456	0				65.00
66.00	06600	PHYSICAL THERAPY	224	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	83	0				67.00
68.00	06800	SPEECH PATHOLOGY	31	0				68.00
69.00	06900	ELECTROCARDIOLOGY	46	0				69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	412	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	180	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,022	0				73.00
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3	0				90.00
91.00	09100	EMERGENCY	1,857	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	608	0				95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,778	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0				194.00
194.01	07951	PAIN CLINIC	0	0				194.01
194.02	07952	OCC HEALTH	0	0				194.02
194.03	07953	FOUNDATION	0	0				194.03
194.04	07954	PHYSICIAN OFFICES	0	0				194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0				194.05
194.06	07956	VACANT SPACE	0	0				194.06
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,778	0	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			22.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			582,812	0	582,812	30.00
43.00	04300	NURSERY			12,607	0	12,607	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			366,603	0	366,603	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM			68,664	0	68,664	52.00
53.00	05300	ANESTHESIOLOGY			7,076	0	7,076	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC			513,400	0	513,400	54.00
54.01	05401	CAT SCAN			0	0	0	54.01
60.00	06000	LABORATORY			191,951	0	191,951	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY			115,417	0	115,417	65.00
66.00	06600	PHYSICAL THERAPY			86,799	0	86,799	66.00
67.00	06700	OCCUPATIONAL THERAPY			42,700	0	42,700	67.00
68.00	06800	SPEECH PATHOLOGY			15,260	0	15,260	68.00
69.00	06900	ELECTROCARDIOLOGY			2,299	0	2,299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT			53,183	0	53,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS			32,271	0	32,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS			272,418	0	272,418	73.00
76.97	07697	CARDIAC REHABILITATION			0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY			0	0	0	76.98
76.99	07699	LITHOTRIPSY			0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC			3,554	0	3,554	90.00
91.00	09100	EMERGENCY			241,288	0	241,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES			271,418	0	271,418	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	2,879,720	0	2,879,720	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN			12,372	0	12,372	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES			57,272	0	57,272	192.00
194.00	07950	OTHER NONREIMBURSABLE			0	0	0	194.00
194.01	07951	PAIN CLINIC			0	0	0	194.01
194.02	07952	OCC HEALTH			0	0	0	194.02
194.03	07953	FOUNDATION			8,060	0	8,060	194.03
194.04	07954	PHYSICIAN OFFICES			13,290	0	13,290	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES			35,369	0	35,369	194.05
194.06	07956	VACANT SPACE			215	0	215	194.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	21,789	0	21,789	201.00
202.00		TOTAL (sum lines 118-201)	0	0	3,028,087	0	3,028,087	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	117,225					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		795,567				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	16,778,002			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,073	11,753	5,217,492	-12,099,323	21,361,481	5.00
7.00	00700	OPERATION OF PLANT	11,508	96,934	356,390	0	1,516,131	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	990	0	0	0	158,357	8.00
9.00	00900	HOUSEKEEPING	1,432	4,867	288,173	0	464,169	9.00
10.00	01000	DIETARY	2,948	7,698	232,505	0	374,738	10.00
11.00	01100	CAFETERIA	1,907	0	131,014	0	78,634	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	401	1,154	447,226	0	521,708	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,683	0	0	0	11,300	14.00
15.00	01500	PHARMACY	1,086	104,223	568,578	0	114,261	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,659	0	0	0	5,090	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,034	92,582	1,997,328	0	2,778,271	30.00
43.00	04300	NURSERY	249	0	76,839	0	96,537	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,976	108,914	982,850	0	1,568,640	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,599	0	405,586	0	510,429	52.00
53.00	05300	ANESTHESIOLOGY	0	6,143	0	0	18,490	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,771	252,249	1,384,240	0	2,402,930	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	2,292	0	0	0	1,753,636	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,971	34,806	515,916	0	700,557	65.00
66.00	06600	PHYSICAL THERAPY	786	11,562	669,568	0	704,723	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	308,598	0	424,447	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	106,188	0	151,757	68.00
69.00	06900	ELECTROCARDIOLOGY	164	0	0	0	10,505	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	407,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	324,079	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,898,995	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	27,862	0	35,064	90.00
91.00	09100	EMERGENCY	7,254	16,558	1,182,586	0	1,491,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	41,323	1,733,287	0	2,318,546	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	107,783	790,766	16,632,226	-12,099,323	20,841,020	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	916	2,481	25,966	0	35,102	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,515	2,169	37,237	0	69,195	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	80,004	194.03
194.04	07954	PHYSICIAN OFFICES	1,700	0	1,728	0	7,204	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	311	151	80,845	0	326,786	194.05
194.06	07956	VACANT SPACE	0	0	0	0	2,170	194.06
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)	359,679	655,117	2,520,849		12,099,323	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.068279	0.823459	0.150247		0.566408	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		2,115,242	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.099021	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS WORKED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	75,644					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	990	291,335				8.00
9.00	00900	HOUSEKEEPING	1,432	11,961	73,222			9.00
10.00	01000	DIETARY	2,948	415	2,948	30,945		10.00
11.00	01100	CAFETERIA	1,907	414	1,907	0	396,286	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	401	0	401	0	14,108	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,683	8,819	3,683	0	0	14.00
15.00	01500	PHARMACY	1,086	0	1,086	0	12,271	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,659	0	1,659	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,034	101,639	17,034	30,945	74,682	30.00
43.00	04300	NURSERY	249	293	249	0	3,097	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,976	76,602	12,976	0	36,209	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,599	294	1,599	0	16,348	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,771	29,036	7,771	0	50,451	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	2,292	721	2,292	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,971	1,778	1,971	0	20,296	65.00
66.00	06600	PHYSICAL THERAPY	786	0	786	0	17,543	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	10,624	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3,656	68.00
69.00	06900	ELECTROCARDIOLOGY	164	0	164	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	1,029	90.00
91.00	09100	EMERGENCY	7,254	56,048	7,254	0	48,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	77,465	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	66,202	288,020	63,780	30,945	386,188	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	916	0	916	0	1,296	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,515	3,315	6,515	0	2,289	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	2,160	194.03
194.04	07954	PHYSICIAN OFFICES	1,700	0	1,700	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	311	0	311	0	4,353	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
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)	2,374,880	279,134	783,496	711,489	203,846	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.395484	0.958120	10.700281	22.992050	0.514391	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	265,260	22,191	60,297	65,289	21,926	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.506689	0.076170	0.823482	2.109840	0.055329	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	MAINTENANCE OF PERSONNEL (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	178,745				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,713,765			14.00
15.00	01500	PHARMACY	0	0	29,193	1,915,027		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	143,730,561	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	74,682	227,940	1,864	8,761,810	30.00
43.00	04300	NURSERY	0	3,097	0	0	416,426	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	36,209	226,404	27,103	14,600,777	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,348	0	0	2,359,572	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,090,381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	69,721	289	45,671,482	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	14,530,656	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	64,270	0	5,128,817	65.00
66.00	06600	PHYSICAL THERAPY	0	0	28,405	102	2,514,815	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	936,652	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	346,342	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	516,673	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	733,675	0	4,625,006	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,022,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	34,117	1,874,763	11,485,153	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	1,297	0	33,442	90.00
91.00	09100	EMERGENCY	0	48,409	129,129	548	20,860,509	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	145,925	9,948	6,829,771	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	178,745	1,690,076	1,914,617	143,730,561	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	253	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,107	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	410	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	20,329	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	841,346	181,189	234,093	77,810	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	4.706962	0.105726	0.122240	0.000541	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	56,357	29,039	106,345	12,778	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.315293	0.016945	0.044154	0.000089	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			17.00	19.00	20.00	21.00	22.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	0					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00	02000	NURSING SCHOOL	0		0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0			0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0		0	0	0	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	PAIN CLINIC	0	0	0	0	0	194.01
194.02	07952	OCC HEALTH	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	0	0	0	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	0	0	0	0	194.05
194.06	07956	VACANT SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet B-1 Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
			17.00	19.00	20.00	21.00	22.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 Date/Time Prepared: 5/22/2015 1:05 pm

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)	
			23.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	CAT SCAN	0	54.01
60.00	06000	LABORATORY	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	194.00
194.01	07951	PAIN CLINIC	0	194.01
194.02	07952	OCC HEALTH	0	194.02
194.03	07953	FOUNDATION	0	194.03
194.04	07954	PHYSICIAN OFFICES	0	194.04
194.05	07955	COMMUNITY & VOLUNTEER SERVICES	0	194.05
194.06	07956	VACANT SPACE	0	194.06
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,296,856		6,296,856	0	6,296,856	30.00
43.00	04300	NURSERY	178,373		178,373	0	178,373	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,300,968		3,300,968	0	3,300,968	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	953,768		953,768	0	953,768	52.00
53.00	05300	ANESTHESIOLOGY	30,094		30,094	7,953	38,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,177,032		4,177,032	0	4,177,032	54.00
54.01	05401	CAT SCAN	0		0	0	0	54.01
60.00	06000	LABORATORY	2,851,944		2,851,944	0	2,851,944	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,202,042	0	1,202,042	0	1,202,042	65.00
66.00	06600	PHYSICAL THERAPY	1,150,371	0	1,150,371	0	1,150,371	66.00
67.00	06700	OCCUPATIONAL THERAPY	670,829	0	670,829	0	670,829	67.00
68.00	06800	SPEECH PATHOLOGY	239,781	0	239,781	0	239,781	68.00
69.00	06900	ELECTROCARDIOLOGY	23,639		23,639	0	23,639	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	718,183		718,183	0	718,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	508,734		508,734	0	508,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,213,593		3,213,593	0	3,213,593	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55,609		55,609	0	55,609	90.00
91.00	09100	EMERGENCY	2,973,368		2,973,368	0	2,973,368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,169,108		1,169,108		1,169,108	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,691,975		3,691,975	0	3,691,975	95.00
200.00		Subtotal (see instructions)	33,406,267	0	33,406,267	7,953	33,414,220	200.00
201.00		Less Observation Beds	1,169,108		1,169,108		1,169,108	201.00
202.00		Total (see instructions)	32,237,159	0	32,237,159	7,953	32,245,112	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,383,473		7,383,473			30.00
43.00	04300	NURSERY	416,426		416,426			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,268,026	10,332,751	14,600,777	0.226082	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,265,627	93,945	2,359,572	0.404212	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	558,848	1,531,533	2,090,381	0.014396	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,081,789	41,589,693	45,671,482	0.091458	0.000000	54.00
54.01	05401	CAT SCAN	0	0	0	0.000000	0.000000	54.01
60.00	06000	LABORATORY	2,829,089	11,701,567	14,530,656	0.196271	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,566,299	3,562,518	5,128,817	0.234370	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	254,508	2,260,307	2,514,815	0.457438	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,979	919,673	936,652	0.716199	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	25,025	321,317	346,342	0.692324	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	423,707	92,966	516,673	0.045752	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,443,738	3,181,268	4,625,006	0.155283	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,465,802	556,475	2,022,277	0.251565	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,049,179	6,435,974	11,485,153	0.279804	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,105	30,337	33,442	1.662849	0.000000	90.00
91.00	09100	EMERGENCY	2,300,732	18,559,777	20,860,509	0.142536	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,378,337	1,378,337	0.848202	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,829,771	6,829,771	0.540571	0.000000	95.00
200.00		Subtotal (see instructions)	34,352,352	109,378,209	143,730,561			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	34,352,352	109,378,209	143,730,561			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.226082	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.404212	52.00
53.00	05300	ANESTHESIOLOGY	0.018201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091458	54.00
54.01	05401	CAT SCAN	0.000000	54.01
60.00	06000	LABORATORY	0.196271	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.234370	65.00
66.00	06600	PHYSICAL THERAPY	0.457438	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.716199	67.00
68.00	06800	SPEECH PATHOLOGY	0.692324	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279804	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.662849	90.00
91.00	09100	EMERGENCY	0.142536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848202	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.540571	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Disallowance	Costs: Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,296,856		6,296,856	0	6,296,856	30.00
43.00	04300	NURSERY	178,373		178,373	0	178,373	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,300,968		3,300,968	0	3,300,968	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	953,768		953,768	0	953,768	52.00
53.00	05300	ANESTHESIOLOGY	30,094		30,094	7,953	38,047	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,177,032		4,177,032	0	4,177,032	54.00
54.01	05401	CAT SCAN	0		0	0	0	54.01
60.00	06000	LABORATORY	2,851,944		2,851,944	0	2,851,944	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,202,042	0	1,202,042	0	1,202,042	65.00
66.00	06600	PHYSICAL THERAPY	1,150,371	0	1,150,371	0	1,150,371	66.00
67.00	06700	OCCUPATIONAL THERAPY	670,829	0	670,829	0	670,829	67.00
68.00	06800	SPEECH PATHOLOGY	239,781	0	239,781	0	239,781	68.00
69.00	06900	ELECTROCARDIOLOGY	23,639		23,639	0	23,639	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	718,183		718,183	0	718,183	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	508,734		508,734	0	508,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,213,593		3,213,593	0	3,213,593	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55,609		55,609	0	55,609	90.00
91.00	09100	EMERGENCY	2,973,368		2,973,368	0	2,973,368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,169,108		1,169,108		1,169,108	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,691,975		3,691,975	0	3,691,975	95.00
200.00		Subtotal (see instructions)	33,406,267	0	33,406,267	7,953	33,414,220	200.00
201.00		Less Observation Beds	1,169,108		1,169,108		1,169,108	201.00
202.00		Total (see instructions)	32,237,159	0	32,237,159	7,953	32,245,112	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,383,473		7,383,473			30.00
43.00	04300	NURSERY	416,426		416,426			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,268,026	10,332,751	14,600,777	0.226082	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,265,627	93,945	2,359,572	0.404212	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	558,848	1,531,533	2,090,381	0.014396	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,081,789	41,589,693	45,671,482	0.091458	0.000000	54.00
54.01	05401	CAT SCAN	0	0	0	0.000000	0.000000	54.01
60.00	06000	LABORATORY	2,829,089	11,701,567	14,530,656	0.196271	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,566,299	3,562,518	5,128,817	0.234370	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	254,508	2,260,307	2,514,815	0.457438	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,979	919,673	936,652	0.716199	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	25,025	321,317	346,342	0.692324	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	423,707	92,966	516,673	0.045752	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,443,738	3,181,268	4,625,006	0.155283	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,465,802	556,475	2,022,277	0.251565	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,049,179	6,435,974	11,485,153	0.279804	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,105	30,337	33,442	1.662849	0.000000	90.00
91.00	09100	EMERGENCY	2,300,732	18,559,777	20,860,509	0.142536	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,378,337	1,378,337	0.848202	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,829,771	6,829,771	0.540571	0.000000	95.00
200.00		Subtotal (see instructions)	34,352,352	109,378,209	143,730,561			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	34,352,352	109,378,209	143,730,561			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.226082	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.404212	52.00
53.00	05300	ANESTHESIOLOGY	0.018201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091458	54.00
54.01	05401	CAT SCAN	0.000000	54.01
60.00	06000	LABORATORY	0.196271	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.234370	65.00
66.00	06600	PHYSICAL THERAPY	0.457438	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.716199	67.00
68.00	06800	SPEECH PATHOLOGY	0.692324	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279804	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.662849	90.00
91.00	09100	EMERGENCY	0.142536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848202	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.540571	95.00
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: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II | Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	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	3,300,968	366,603	2,934,365	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	953,768	68,664	885,104	0	0	52.00
53.00	05300	ANESTHESIOLOGY	30,094	7,076	23,018	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,177,032	513,400	3,663,632	0	0	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	2,851,944	191,951	2,659,993	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,202,042	115,417	1,086,625	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,150,371	86,799	1,063,572	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	670,829	42,700	628,129	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	239,781	15,260	224,521	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,639	2,299	21,340	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	718,183	53,183	665,000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	508,734	32,271	476,463	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,213,593	272,418	2,941,175	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	55,609	3,554	52,055	0	0	90.00
91.00	09100	EMERGENCY	2,973,368	241,288	2,732,080	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,169,108	108,208	1,060,900	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,691,975	271,418	3,420,557	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	26,931,038	2,392,509	24,538,529	0	0	200.00
201.00		Less Observation Beds	1,169,108	108,208	1,060,900	0	0	201.00
202.00		Total (line 200 minus line 201)	25,761,930	2,284,301	23,477,629	0	0	202.00

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

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II | Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,300,968	14,600,777	0.226082	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	953,768	2,359,572	0.404212	52.00
53.00	05300	ANESTHESIOLOGY	30,094	2,090,381	0.014396	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,177,032	45,671,482	0.091458	54.00
54.01	05401	CAT SCAN	0	0	0.000000	54.01
60.00	06000	LABORATORY	2,851,944	14,530,656	0.196271	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,202,042	5,128,817	0.234370	65.00
66.00	06600	PHYSICAL THERAPY	1,150,371	2,514,815	0.457438	66.00
67.00	06700	OCCUPATIONAL THERAPY	670,829	936,652	0.716199	67.00
68.00	06800	SPEECH PATHOLOGY	239,781	346,342	0.692324	68.00
69.00	06900	ELECTROCARDIOLOGY	23,639	516,673	0.045752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	718,183	4,625,006	0.155283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	508,734	2,022,277	0.251565	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,213,593	11,485,153	0.279804	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	55,609	33,442	1.662849	90.00
91.00	09100	EMERGENCY	2,973,368	20,860,509	0.142536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,169,108	1,378,337	0.848202	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	3,691,975	6,829,771	0.540571	95.00
200.00		Subtotal (sum of lines 50 thru 199)	26,931,038	135,930,662		200.00
201.00		Less Observation Beds	1,169,108	0		201.00
202.00		Total (line 200 minus line 201)	25,761,930	135,930,662		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I | Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	582,812	0	582,812	6,851	85.07	30.00
43.00	NURSERY	12,607		12,607	555	22.72	43.00
200.00	Total (lines 30-199)	595,419		595,419	7,406		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,133	181,454	30.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	2,133	181,454	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/22/2015 1:05 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	366,603	14,600,777	0.025108	1,274,376	31,997	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,664	2,359,572	0.029100	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7,076	2,090,381	0.003385	152,963	518	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	513,400	45,671,482	0.011241	1,751,297	19,686	54.00
54.01	05401	CAT SCAN	0	0	0.000000	0	0	54.01
60.00	06000	LABORATORY	191,951	14,530,656	0.013210	1,149,991	15,191	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	115,417	5,128,817	0.022504	701,844	15,794	65.00
66.00	06600	PHYSICAL THERAPY	86,799	2,514,815	0.034515	126,800	4,377	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,700	936,652	0.045588	7,224	329	67.00
68.00	06800	SPEECH PATHOLOGY	15,260	346,342	0.044060	13,563	598	68.00
69.00	06900	ELECTROCARDIOLOGY	2,299	516,673	0.004450	337,952	1,504	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,183	4,625,006	0.011499	278,690	3,205	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,271	2,022,277	0.015958	646,684	10,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,418	11,485,153	0.023719	1,865,914	44,258	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,554	33,442	0.106274	966	103	90.00
91.00	09100	EMERGENCY	241,288	20,860,509	0.011567	1,049,277	12,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	108,208	1,378,337	0.078506	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,121,091	129,100,891		9,357,541	160,017	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,851	0.00	2,133	0	30.00
43.00	04300	NURSERY	555	0.00	0	0	43.00
200.00		Total (lines 30-199)	7,406		2,133	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/22/2015 1:05 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,600,777	0.000000	0.000000	1,274,376	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,359,572	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,090,381	0.000000	0.000000	152,963	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,671,482	0.000000	0.000000	1,751,297	54.00
54.01	05401	CAT SCAN	0	0	0.000000	0.000000	0	54.01
60.00	06000	LABORATORY	0	14,530,656	0.000000	0.000000	1,149,991	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,128,817	0.000000	0.000000	701,844	65.00
66.00	06600	PHYSICAL THERAPY	0	2,514,815	0.000000	0.000000	126,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	936,652	0.000000	0.000000	7,224	67.00
68.00	06800	SPEECH PATHOLOGY	0	346,342	0.000000	0.000000	13,563	68.00
69.00	06900	ELECTROCARDIOLOGY	0	516,673	0.000000	0.000000	337,952	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,625,006	0.000000	0.000000	278,690	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,022,277	0.000000	0.000000	646,684	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,485,153	0.000000	0.000000	1,865,914	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	33,442	0.000000	0.000000	966	90.00
91.00	09100	EMERGENCY	0	20,860,509	0.000000	0.000000	1,049,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,378,337	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	129,100,891			9,357,541	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,144,508	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	267,474	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,251,513	0	54.00
54.01	05401	CAT SCAN	0	0	0	54.01
60.00	06000	LABORATORY	0	114,752	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	505,852	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	435,684	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	224,039	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	79,568	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,725,809	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	6,969	0	90.00
91.00	09100	EMERGENCY	0	3,911,863	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	367,157	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	19,035,188	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.226082	2,144,508	0	0	484,835	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.404212	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014396	267,474	0	0	3,851	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091458	9,251,513	0	0	846,125	54.00
54.01	05401	CAT SCAN	0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY	0.196271	114,752	0	0	22,522	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.234370	505,852	0	0	118,557	65.00
66.00	06600	PHYSICAL THERAPY	0.457438	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.716199	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.692324	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045752	435,684	0	0	19,933	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155283	224,039	0	0	34,789	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251565	79,568	0	0	20,017	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279804	1,725,809	0	0	482,888	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.662849	6,969	0	0	11,588	90.00
91.00	09100	EMERGENCY	0.142536	3,911,863	0	0	557,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848202	367,157	0	0	311,423	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.540571		0			95.00
200.00		Subtotal (see instructions)		19,035,188	0	0	2,914,109	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		19,035,188	0	0	2,914,109	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	CAT SCAN	0	0	54.01
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	582,812	0	582,812	6,851	85.07	30.00
43.00	NURSERY	12,607		12,607	555	22.72	43.00
200.00	Total (lines 30-199)	595,419		595,419	7,406		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	306	26,031	30.00
43.00	NURSERY	76	1,727	43.00
200.00	Total (lines 30-199)	382	27,758	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	366,603	14,600,777	0.025108	885,541	22,234	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,664	2,359,572	0.029100	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7,076	2,090,381	0.003385	82,331	279	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	513,400	45,671,482	0.011241	316,993	3,563	54.00
54.01	05401	CAT SCAN	0	0	0.000000	0	0	54.01
60.00	06000	LABORATORY	191,951	14,530,656	0.013210	313,770	4,145	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	115,417	5,128,817	0.022504	134,958	3,037	65.00
66.00	06600	PHYSICAL THERAPY	86,799	2,514,815	0.034515	8,573	296	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,700	936,652	0.045588	255	12	67.00
68.00	06800	SPEECH PATHOLOGY	15,260	346,342	0.044060	334	15	68.00
69.00	06900	ELECTROCARDIOLOGY	2,299	516,673	0.004450	36,920	164	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,183	4,625,006	0.011499	146,368	1,683	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,271	2,022,277	0.015958	54,874	876	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	272,418	11,485,153	0.023719	621,243	14,735	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,554	33,442	0.106274	621	66	90.00
91.00	09100	EMERGENCY	241,288	20,860,509	0.011567	191,983	2,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	108,208	1,378,337	0.078506	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,121,091	129,100,891		2,794,764	53,326	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	6,851	0.00	306	0	30.00
43.00	04300	NURSERY	555	0.00	76	0	43.00
200.00		Total (lines 30-199)	7,406		382	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	CAT SCAN	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,600,777	0.000000	0.000000	885,541	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,359,572	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,090,381	0.000000	0.000000	82,331	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,671,482	0.000000	0.000000	316,993	54.00
54.01	05401	CAT SCAN	0	0	0.000000	0.000000	0	54.01
60.00	06000	LABORATORY	0	14,530,656	0.000000	0.000000	313,770	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,128,817	0.000000	0.000000	134,958	65.00
66.00	06600	PHYSICAL THERAPY	0	2,514,815	0.000000	0.000000	8,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	936,652	0.000000	0.000000	255	67.00
68.00	06800	SPEECH PATHOLOGY	0	346,342	0.000000	0.000000	334	68.00
69.00	06900	ELECTROCARDIOLOGY	0	516,673	0.000000	0.000000	36,920	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,625,006	0.000000	0.000000	146,368	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,022,277	0.000000	0.000000	54,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,485,153	0.000000	0.000000	621,243	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	33,442	0.000000	0.000000	621	90.00
91.00	09100	EMERGENCY	0	20,860,509	0.000000	0.000000	191,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,378,337	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	129,100,891			2,794,764	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	CAT SCAN	0	0	0		54.01
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.226082	0	1,698,816	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.404212	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014396	0	219,574	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091458	0	5,744,812	0	0	54.00
54.01	05401	CAT SCAN	0.000000	0	0	0	0	54.01
60.00	06000	LABORATORY	0.196271	0	1,508,448	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.234370	0	202,822	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.457438	0	324,836	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.716199	0	195,673	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.692324	0	148,036	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045752	0	174,215	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155283	0	230,413	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251565	0	54,960	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279804	0	917,591	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.662849	0	2,691	0	0	90.00
91.00	09100	EMERGENCY	0.142536	0	4,387,636	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848202	0	481,225	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.540571	0	815,052			95.00
200.00		Subtotal (see instructions)		0	17,106,800	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	17,106,800	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	384,072	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,161	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	525,409	0	54.00
54.01	05401	CAT SCAN	0	0	54.01
60.00	06000	LABORATORY	296,065	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	47,535	0	65.00
66.00	06600	PHYSICAL THERAPY	148,592	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,141	0	67.00
68.00	06800	SPEECH PATHOLOGY	102,489	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,971	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,779	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,826	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	256,746	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	4,475	0	90.00
91.00	09100	EMERGENCY	625,396	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	408,176	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	440,593		95.00
200.00		Subtotal (see instructions)	3,440,426	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,440,426	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,851	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,851	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)	5,579	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,133	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)	6,296,856	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)	6,296,856	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)	6,296,856	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)	919.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,960,462	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)	1,960,462	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,808,512	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,768,974	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)	181,454	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	160,017	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	341,471	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,427,503	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,272	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	919.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,169,108	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	582,812	6,296,856	0.092556	1,169,108	108,208	90.00
91.00	Nursing School cost	0	6,296,856	0.000000	1,169,108	0	91.00
92.00	Allied health cost	0	6,296,856	0.000000	1,169,108	0	92.00
93.00	All other Medical Education	0	6,296,856	0.000000	1,169,108	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:05 pm

		Title XIX	Hospital	PPS	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			6,851	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			6,851	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)			5,579	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)			306	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)			555	15.00
16.00	Nursery days (title V or XIX only)			76	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)			6,296,856	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)			6,296,856	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)			6,296,856	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)			919.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			281,248	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)			281,248	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:05 pm

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)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	178,373	555	321.39	76	24,426	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	568,690	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	874,364	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)	27,758	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	53,326	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	81,084	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	793,280	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,272	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	919.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,169,108	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	582,812	6,296,856	0.092556	1,169,108	108,208	90.00
91.00	Nursing School cost	0	6,296,856	0.000000	1,169,108	0	91.00
92.00	Allied health cost	0	6,296,856	0.000000	1,169,108	0	92.00
93.00	All other Medical Education	0	6,296,856	0.000000	1,169,108	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,086,438		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.226082	1,274,376	288,113	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.404212	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.018201	152,963	2,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091458	1,751,297	160,170	54.00
54.01	05401	CAT SCAN	0.000000	0	0	54.01
60.00	06000	LABORATORY	0.196271	1,149,991	225,710	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.234370	701,844	164,491	65.00
66.00	06600	PHYSICAL THERAPY	0.457438	126,800	58,003	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.716199	7,224	5,174	67.00
68.00	06800	SPEECH PATHOLOGY	0.692324	13,563	9,390	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045752	337,952	15,462	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155283	278,690	43,276	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251565	646,684	162,683	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279804	1,865,914	522,090	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.662849	966	1,606	90.00
91.00	09100	EMERGENCY	0.142536	1,049,277	149,560	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848202	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		9,357,541	1,808,512	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)		9,357,541		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/22/2015 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,605,706		30.00
43.00	04300	NURSERY		290,136		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.226082	885,541	200,205	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.404212	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.018201	82,331	1,499	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.091458	316,993	28,992	54.00
54.01	05401	CAT SCAN	0.000000	0	0	54.01
60.00	06000	LABORATORY	0.196271	313,770	61,584	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.234370	134,958	31,630	65.00
66.00	06600	PHYSICAL THERAPY	0.457438	8,573	3,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.716199	255	183	67.00
68.00	06800	SPEECH PATHOLOGY	0.692324	334	231	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045752	36,920	1,689	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.155283	146,368	22,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.251565	54,874	13,804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.279804	621,243	173,826	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.662849	621	1,033	90.00
91.00	09100	EMERGENCY	0.142536	191,983	27,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848202	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,794,764	568,690	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)		2,794,764		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,253,310		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		765,215		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)		30,040		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		27.52		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.16		30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.07		31.00
32.00	Sum of lines 30 and 31		21.23		32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.73		33.00
34.00	Disproportionate share adjustment (see instructions)		50,787		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000042081	0.000035440	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		380,681	271,033	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		284,728	68,315	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		353,043		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		3,452,395		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)		3,452,395		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		245,681		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,698,076		59.00
60.00	Primary payer payments		17,918		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,680,158		61.00
62.00	Deductibles billed to program beneficiaries		515,036		62.00
63.00	Coinsurance billed to program beneficiaries		2,471		63.00
64.00	Allowable bad debts (see instructions)		2,198		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		1,429		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		-23,258		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,164,080		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		13,616		70.93
70.94	HRR adjustment amount (see instructions)		-10,499		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/22/2015 1:05 pm
	Title XVIII	Hospital	PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2014	295,356		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2015	101,144		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)		3,563,697		71.00
71.01	Sequestration adjustment (see instructions)		71,274		71.01
72.00	Interim payments		3,480,368		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)		12,055		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,253,310	0	2,253,310	0	2,253,310	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	765,215	0	0	765,215	765,215	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	30,040	0	25,706	4,334	30,040	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0673	0.0673	0.0673	0.0673		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	50,787	0	37,912	12,875	50,787	11.00
11.01	Uncompensated care payments	36.00	353,043	0	284,728	68,315	353,043	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,452,395	0	2,601,656	850,739	3,452,395	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,452,395	0	2,601,656	850,739	3,452,395	15.00
16.00	Payment for inpatient program capital	50.00	245,681	0	182,856	62,825	245,681	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150146

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

Worksheet E Part A Exhibit 4
Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	2,784,512	913,564	3,698,076	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	239,609	0	177,741	61,868	239,609	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,072	0	5,115	957	6,072	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	245,681	0	182,856	62,825	245,681	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.106071	0.110714		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			295,356		295,356	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				101,144	101,144	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/22/2015 1:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,914,109	2.00
3.00	PPS payments	2,843,271	3.00
4.00	Outlier payment (see instructions)	5,763	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.864	5.00
6.00	Line 2 times line 5	2,517,790	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	0	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)	2,849,034	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	667,995	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,181,039	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,181,039	30.00
31.00	Primary payer payments	537	31.00
32.00	Subtotal (line 30 minus line 31)	2,180,502	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)	49,287	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	32,037	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,795	36.00
37.00	Subtotal (see instructions)	2,212,539	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,212,539	40.00
40.01	Sequestration adjustment (see instructions)	44,251	40.01
41.00	Interim payments	2,193,492	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-25,204	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: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 5/22/2015 1:05 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,480,368		2,156,892	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	08/08/2014	36,600	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		36,600	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)		3,480,368		2,193,492	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		12,055		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		25,204	6.02
7.00	Total Medicare program liability (see instructions)		3,492,423		2,168,288	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: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/22/2015 1:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,632	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,133	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,520	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	5,579	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	143,730,561	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,071,216	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)	696,491	8.00
9.00	Sequestration adjustment amount (see instructions)	13,930	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	682,561	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	685,426	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)	-2,865	32.00

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

Provider CCN: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/22/2015 1:05 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,879	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,531,428	0	0	0	4.00
5.00	Other receivable	4,286,344	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,638,366	0	0	0	6.00
7.00	Inventory	224,952	0	0	0	7.00
8.00	Prepaid expenses	26,765	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,433,002	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	637,235	0	0	0	13.00
14.00	Accumulated depreciation	-259,285	0	0	0	14.00
15.00	Buildings	3,109,044	0	0	0	15.00
16.00	Accumulated depreciation	-939,094	0	0	0	16.00
17.00	Leasehold improvements	57,402	0	0	0	17.00
18.00	Accumulated depreciation	-11,662	0	0	0	18.00
19.00	Fixed equipment	52,820	0	0	0	19.00
20.00	Accumulated depreciation	-31,829	0	0	0	20.00
21.00	Automobiles and trucks	81,334	0	0	0	21.00
22.00	Accumulated depreciation	-81,334	0	0	0	22.00
23.00	Major movable equipment	10,792,613	0	0	0	23.00
24.00	Accumulated depreciation	-9,638,016	0	0	0	24.00
25.00	Minor equipment depreciable	951,470	0	0	0	25.00
26.00	Accumulated depreciation	-390,125	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)	4,330,573	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	6,366	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	844,675	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	851,041	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,614,616	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	625,949	0	0	0	37.00
38.00	Salaries, wages, and fees payable	732,090	0	0	0	38.00
39.00	Payroll taxes payable	124,827	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	997,560	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,480,426	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	301,073	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	301,073	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,781,499	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,833,117				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	13,833,117	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,614,616	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet G-1 Date/Time Prepared: 5/22/2015 1:05 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		13,836,492		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,148,557				2.00
3.00	Total (sum of line 1 and line 2)		23,985,049		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,985,049		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ASSET TRANSFERS	10,151,932		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)		10,151,932		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,833,117		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	ASSET TRANSFERS		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: 150146 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/22/2015 1:05 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	7,255,605		7,255,605	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,255,605		7,255,605	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,255,605		7,255,605	17.00
18.00	Ancillary services	27,560,375	0	27,560,375	18.00
19.00	Outpatient services	0	107,558,529	107,558,529	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	6,869,937	6,869,937	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)	34,815,980	114,428,466	149,244,446	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,993,197		29.00
30.00	PROVISION FOR BAD DEBT	9,127,668			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)		9,127,668		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)		51,120,865		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/22/2015 1:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	149,244,446	1.00
2.00	Less contractual allowances and discounts on patients' accounts	90,006,726	2.00
3.00	Net patient revenues (line 1 minus line 2)	59,237,720	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	51,120,865	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,116,855	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,965	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	119,863	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	GAIN/(LOSS) ON SALE OF CAPITAL ASSET	-10,196	24.01
24.02	EMS SUBSIDY	168,694	24.02
24.03	OTHER REVENUE	1,749,376	24.03
25.00	Total other income (sum of lines 6-24)	2,031,702	25.00
26.00	Total (line 5 plus line 25)	10,148,557	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)	10,148,557	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150146	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/22/2015 1:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	239,609	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	6,072	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)	15.67	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	245,681	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