

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: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/21/2015 1:49 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/21/2015 Time: 1:49 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)**

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPT. OF LAGRANGE CTY IN ( 151323 ) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	113,803	-26,258	156,270	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	-79,131	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	34,672	-26,258	156,270	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: 151323		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 9:27 am							
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 207 NORTH TOWNLINE ROAD		PO Box:						1.00				
2.00	City: LAGRANGE		State: IN		Zip Code: 46761-1325		County: LAGRANGE		2.00				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
		V		XVIII	XIX								
3.00	Hospital and Hospital-Based Component Identification:												
	Hospital		COMMUNITY HOSPITAL OF LAGRANGE COUNTY IN		151323	99915	1	05/01/2005	N	O	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		SWING BEDS		15Z323	99915		05/01/2005	N	O	N	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	
17.10	Hospital-Based (CORF) I											17.10	
17.20	Hospital-Based (OPT) I											17.20	
17.30	Hospital-Based (OOT) I											17.30	
17.40	Hospital-Based (OSP) I											17.40	
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.						N	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 days	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.						0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151323		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 9:27 am		
	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		
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.							25.00
					Urban/Rural	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		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)				N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				N	N	40.00	
					V	XVIII	XIX	
					1.00	2.00	3.00	
<b>Prospective Payment System (PPS)-Capital</b>								
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
<b>Teaching Hospitals</b>								
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151323

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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/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
		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	

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Provider CCN: 151323

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From 01/01/2014  
To 12/31/2014

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

		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	
				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151323		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 9:27 am	
		1.00	2.00	3.00			
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					
<b>Long Term Care Hospital PPS</b>							
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		
<b>TEFRA Providers</b>							
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		
		V		XIX			
		1.00		2.00			
<b>Title V and XIX Services</b>							
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	
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y	105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N	106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N	107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	108.00		
		Physical		Speech		Respiratory	
		1.00		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		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	
<b>Miscellaneous Cost Reporting Information</b>							
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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 9:27 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	37,474	875	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00	
<b>Transplant Center Information</b>					
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	
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	
<b>All Providers</b>					
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	
		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 PHYSICIANS SERVICE		Contractor's Number: 08101	
142.00	Street: 10501 CORPORATE DRIVE	PO Box: 5600			
143.00	City: FORT WAYNE	State: IN		Zip Code: 46845	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N		145.00	
				1.00	
				2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00	
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC				
161.10	CORF				
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151323		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 9:27 am	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40	
						1.00	
<b>Multi campus</b>							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	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
						1.00	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>							
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)					199,373	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)					0.00	169.00
		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. 1, 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: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/21/2015 9:27 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	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 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	04/30/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		Y	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151323

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/21/2015 9:27 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
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: 151323

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/21/2015 9:27 am

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
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)	04/30/2015	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
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: 151323

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Trips	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	66,960.00	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)		25	9,125	66,960.00	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)		25	9,125	66,960.00	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
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				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: 151323

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

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)	1,015	230	2,528			1.00
2.00 HMO and other (see instructions)	474	4				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	401	0	401			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	155			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,416	230	3,084			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		197	593			13.00
14.00 Total (see instructions)	1,416	427	3,677	0.00	176.20	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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
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	176.20	27.00
28.00 Observation Bed Days		58	663			28.00
29.00 Ambulance Trips	4,401					29.00
30.00 Employee discount days (see instruction)			47			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	53	0	227			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: 151323

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	273	101	933	1.00
2.00 HMO and other (see instructions)				112	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		273	101	933	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
25.10 CMHC - CORF	0.00						25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00						25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00						25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00						25.40
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



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151323

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

Worksheet A  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		1,501,280	1,501,280	-253,176	1,248,104	1.00
1.01	00101		0	0	16,040	16,040	1.01
2.00	00200		0	0	511,952	511,952	2.00
2.01	00201		0	0	19,818	19,818	2.01
3.00	00300		0	0	0	0	3.00
4.00	00400	1,335,998	2,686,267	4,022,265	0	4,022,265	4.00
5.00	00500	5,451,811	2,764,766	8,216,577	-45,988	8,170,589	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	254,829	740,240	995,069	-23,777	971,292	7.00
8.00	00800	0	77,592	77,592	0	77,592	8.00
9.00	00900	161,597	26,442	188,039	-32	188,007	9.00
10.00	01000	321,207	261,063	582,270	-347,165	235,105	10.00
11.00	01100	0	0	0	345,029	345,029	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	274,899	676	275,575	-45	275,530	13.00
14.00	01400	0	-21,917	-21,917	-3	-21,920	14.00
15.00	01500	404,165	1,105,032	1,509,197	-1,018,145	491,052	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,467,342	229,681	1,697,023	-561,214	1,135,809	30.00
43.00	04300	0	0	0	141,774	141,774	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	711,145	377,684	1,088,829	-58,998	1,029,831	50.00
52.00	05200	0	0	0	414,989	414,989	52.00
53.00	05300	0	663,813	663,813	-170	663,643	53.00
54.00	05400	568,241	472,573	1,040,814	-88,055	952,759	54.00
60.00	06000	0	843,681	843,681	-1,274	842,407	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	284,824	26,762	311,586	-4,501	307,085	65.00
66.00	06600	488,441	11,261	499,702	-176,633	323,069	66.00
67.00	06700	0	0	0	85,027	85,027	67.00
68.00	06800	0	0	0	63,502	63,502	68.00
69.00	06900	0	1,325	1,325	0	1,325	69.00
71.00	07100	0	524,554	524,554	-209,013	315,541	71.00
72.00	07200	0	0	0	208,143	208,143	72.00
73.00	07300	0	0	0	1,018,650	1,018,650	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	3,685	472	4,157	1,556	5,713	90.00
90.01	09001	108,771	97,744	206,515	-564	205,951	90.01
91.00	09100	646,861	1,528,103	2,174,964	-41,054	2,133,910	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	869,454	331,681	1,201,135	-194	1,200,941	95.00
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	157,724	157,724	-157,724	0	113.00
118.00		13,353,270	14,408,499	27,761,769	-161,245	27,600,524	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	7,342	7,342	0	7,342	190.00
192.00	19200	0	1,884	1,884	-519	1,365	192.00
194.00	07950	0	-161,764	-161,764	161,764	0	194.00
194.01	07951	17,086	7,775	24,861	0	24,861	194.01
194.03	07952	10,961	80,379	91,340	0	91,340	194.03
194.04	07954	0	0	0	0	0	194.04
194.06	07953	0	0	0	0	0	194.06
200.00		13,381,317	14,344,115	27,725,432	0	27,725,432	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151323

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

Worksheet A  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	17,365	1,265,469	1.00
1.01	00101	EMS WEST STATION	0	16,040	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	511,952	2.00
2.01	00201	EMS WEST STATION EQUIP.	0	19,818	2.01
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-560,683	3,461,582	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,753,200	6,417,389	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-4,209	967,083	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	77,592	8.00
9.00	00900	HOUSEKEEPING	-27	187,980	9.00
10.00	01000	DIETARY	0	235,105	10.00
11.00	01100	CAFETERIA	-202,612	142,417	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	275,530	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-21,920	14.00
15.00	01500	PHARMACY	0	491,052	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	12,619	1,148,428	30.00
43.00	04300	NURSERY	0	141,774	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,029,831	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	414,989	52.00
53.00	05300	ANESTHESIOLOGY	-632,220	31,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	952,759	54.00
60.00	06000	LABORATORY	0	842,407	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	307,085	65.00
66.00	06600	PHYSICAL THERAPY	-79	322,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	85,027	67.00
68.00	06800	SPEECH PATHOLOGY	-10,976	52,526	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,325	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	315,541	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	208,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-277,569	741,081	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	5,713	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	-100	205,851	90.01
91.00	09100	EMERGENCY	-882,359	1,251,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-300	1,200,641	95.00
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,294,350	23,306,174	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,342	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,365	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	194.00
194.01	07951	FOUNDATION	0	24,861	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	91,340	194.03
194.04	07954	ER PHYSICIAN	0	0	194.04
194.06	07953	SHIPSEWANA RADIOLOGY AND LAB	0	0	194.06
200.00		TOTAL (SUM OF LINES 118-199)	-4,294,350	23,431,082	200.00

RECLASSIFICATIONS

Provider CCN: 151323

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

Worksheet A-6  
Date/Time Prepared:  
5/21/2015 9:27 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
<b>A - REHAB THERAPY RECLASS</b>					
1.00	OCCUPATIONAL THERAPY	67.00	89,278	2,058	1.00
2.00	SPEECH PATHOLOGY	68.00	62,071	1,431	2.00
	0		151,349	3,489	
<b>B - OB RECLASS</b>					
1.00	NURSERY	43.00	130,280	11,494	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	381,344	33,645	2.00
	0		511,624	45,139	
<b>C - CLINIC DIETICIAN</b>					
1.00	CLINIC	90.00	1,556	0	1.00
	0		1,556	0	
<b>F - CAFETERIA RECLASS</b>					
1.00	CAFETERIA	11.00	189,783	155,246	1.00
	0		189,783	155,246	
<b>G - INSURANCE RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	35,410	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,920	2.00
	0		0	47,330	
<b>H - DRUGS CHARGED TO PATIENTS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,025,289	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	1,025,289	
<b>I - SALARY RECLASS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,453,067	1.00
	0		0	2,453,067	
<b>J - OCCUPATIONAL HEALTH RECLASS</b>					
1.00	OCCUPATIONAL HEALTH	194.00	0	161,764	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	161,764	
<b>K - DEPRECIATION</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	426,395	1.00
2.00	EMS WEST STATION	1.01	0	16,040	2.00
3.00	EMS WEST STATION EQUIP.	2.01	0	19,624	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	8,088	4.00
	0		0	470,147	
<b>L - BLDG &amp; LEASE EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	23,837	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	73,637	2.00
3.00	EMS WEST STATION EQUIP.	2.01	0	194	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	97,668	
<b>M - INTEREST RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	157,724	1.00
	0		0	157,724	
<b>N - IMPLANTABLE MEDICAL SUPPLIES</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	208,143	1.00
	0		0	208,143	
500.00	Grand Total: Increases		854,312	4,825,006	500.00

RECLASSIFICATIONS

Provider CCN: 151323

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

Worksheet A-6  
Date/Time Prepared:  
5/21/2015 9:27 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - REHAB THERAPY RECLASS</b>							
1.00	PHYSICAL THERAPY	66.00	151,349	3,489	0		1.00
2.00		0.00	0	0	0		2.00
	0		151,349	3,489			
<b>B - OB RECLASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	511,624	45,139	0		1.00
2.00		0.00	0	0	0		2.00
	0		511,624	45,139			
<b>C - CLINIC DIETICIAN</b>							
1.00	DIETARY	10.00	1,556	0	0		1.00
	0		1,556	0			
<b>F - CAFETERIA RECLASS</b>							
1.00	DIETARY	10.00	189,783	155,246	0		1.00
	0		189,783	155,246			
<b>G - INSURANCE RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	47,330	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	47,330			
<b>H - DRUGS CHARGED TO PATIENTS</b>							
1.00	PHARMACY	15.00	0	1,017,584	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,450	0		2.00
3.00	OPERATING ROOM	50.00	0	2,222	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	888	0		4.00
5.00	EMERGENCY	91.00	0	1,992	0		5.00
6.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	153	0		6.00
	0		0	1,025,289			
<b>I - SALARY RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	2,453,067	0	0		1.00
	0		2,453,067	0			
<b>J - OCCUPATIONAL HEALTH RECLASS</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	87,030	0		1.00
2.00	LABORATORY	60.00	0	1,274	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	683	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	20,375	0		4.00
5.00	OCCUPATIONAL THERAPY	67.00	0	6,309	0		5.00
6.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	717	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,639	0		7.00
8.00	EMERGENCY	91.00	0	37,993	0		8.00
9.00	OPERATING ROOM	50.00	0	574	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	170	0		10.00
	0		0	161,764			
<b>K - DEPRECIATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	470,147	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	0		4.00
	0		0	470,147			
<b>L - BLDG &amp; LEASE EXPENSE</b>							
1.00	OPERATION OF PLANT	7.00	0	23,700	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	137	10		2.00
3.00	AMBULANCE SERVICES	95.00	0	194	10		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	6,746	0		4.00
5.00	OPERATION OF PLANT	7.00	0	77	0		5.00
6.00	HOUSEKEEPING	9.00	0	32	0		6.00
7.00	DIETARY	10.00	0	580	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	3	0		8.00
9.00	PHARMACY	15.00	0	561	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	2,001	0		10.00
11.00	OPERATING ROOM	50.00	0	56,202	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	3,818	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,420	0		13.00
14.00	EMERGENCY	91.00	0	1,069	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	519	0		15.00
16.00	LI FEBRIDGE SENIOR CARE	90.01	0	564	0		16.00
17.00	NURSING ADMINISTRATION	13.00	0	45	0		17.00
	0		0	97,668			
<b>M - INTEREST RECLASS</b>							
1.00	INTEREST EXPENSE	113.00	0	157,724	11		1.00
	0		0	157,724			

Provider CCN: 151323

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

Worksheet A-6  
Date/Time Prepared:  
5/21/2015 9:27 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	N - IMPLANTABLE MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	208,143	0	1.00	
500.00	Grand Total: Decreases		3,307,379	2,371,939		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151323

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	265,000	0	0	0	1.00
2.00	Land Improvements	1,965,610	7,110	0	7,110	2.00
3.00	Buildings and Fixtures	13,245,217	0	0	0	3.00
4.00	Building Improvements	29,098	0	0	0	4.00
5.00	Fixed Equipment	7,635,336	128,062	0	128,062	5.00
6.00	Movable Equipment	7,162,293	400	0	400	6.00
7.00	HIT designated Assets	1,229,965	199,373	0	199,373	7.00
8.00	Subtotal (sum of lines 1-7)	31,532,519	334,945	0	334,945	8.00
9.00	Reconciling Items	400	28,042	0	28,042	9.00
10.00	Total (line 8 minus line 9)	31,532,119	306,903	0	306,903	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	265,000	0			1.00
2.00	Land Improvements	1,972,720	185,270			2.00
3.00	Buildings and Fixtures	13,245,217	46,306			3.00
4.00	Building Improvements	29,098	13,778			4.00
5.00	Fixed Equipment	7,763,398	506,894			5.00
6.00	Movable Equipment	7,082,444	3,194,965			6.00
7.00	HIT designated Assets	1,429,338	0			7.00
8.00	Subtotal (sum of lines 1-7)	31,787,215	3,947,213			8.00
9.00	Reconciling Items	28,042	0			9.00
10.00	Total (line 8 minus line 9)	31,759,173	3,947,213			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151323

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/21/2015 9:27 am

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	1,490,266	0	0	0	11,014	1.00
1.01	EMS WEST STATION	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	1,490,266	0	0	0	11,014	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	1,501,280	1.00
1.01	EMS WEST STATION	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
2.01	EMS WEST STATION EQUIP.	0	0	2.01
3.00	Total (sum of lines 1-2)	0	1,501,280	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151323

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/21/2015 9:27 am

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	22,954,626	0	22,954,626	0.763514	0	1.00
1.01	EMS WEST STATION	320,808	0	320,808	0.010671	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	6,924,292	293,428	6,630,864	0.220555	0	2.00
2.01	EMS WEST STATION EQUIP.	158,153	0	158,153	0.005260	0	2.01
3.00	Total (sum of lines 1-2)	30,357,879	293,428	30,064,451	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	1,038,059	23,837	1.00
1.01	EMS WEST STATION	0	0	0	16,040	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	426,395	73,637	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	19,624	194	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,500,118	97,668	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	157,149	35,410	11,014	0	1,265,469	1.00
1.01	EMS WEST STATION	0	0	0	0	16,040	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,920	0	0	511,952	2.00
2.01	EMS WEST STATION EQUIP.	0	0	0	0	19,818	2.01
3.00	Total (sum of lines 1-2)	157,149	47,330	11,014	0	1,813,279	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151323

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

Worksheet A-8

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-575	CAP REL COSTS-BLDG & FIXT	1.00		11	1.00
1.01 Investment income - EMS WEST STATION (chapter 2)			EMS WEST STATION	1.01			1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00			2.00
2.01 Investment income - EMS WEST STATION EQUIP. (chapter 2)			EMS WEST STATION EQUIP.	2.01			2.01
3.00 Investment income - other (chapter 2)		0		0.00			3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00			4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00			5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00			6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00			7.00
8.00 Television and radio service (chapter 21)	A	-4,209	OPERATION OF PLANT	7.00			8.00
9.00 Parking lot (chapter 21)		0		0.00			9.00
10.00 Provider-based physician adjustment	A-8-2	-1,693,835					10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00			11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-1,701,114					12.00
13.00 Laundry and linen service		0		0.00			13.00
14.00 Cafeteria-employees and guests	B	-202,612	CAFETERIA	11.00			14.00
15.00 Rental of quarters to employee and others		0		0.00			15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00			16.00
17.00 Sale of drugs to other than patients		0		0.00			17.00
18.00 Sale of medical records and abstracts		0		0.00			18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00			19.00
20.00 Vending machines		0		0.00			20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00			21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00			22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1.00			26.00
26.01 Depreciation - EMS WEST STATION			EMS WEST STATION	1.01			26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00			27.00
27.01 Depreciation - EMS WEST STATION EQUIP.			EMS WEST STATION EQUIP.	2.01			27.01
28.00 Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00			28.00
29.00 Physicians' assistant		0		0.00			29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00			30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151323

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

Worksheet A-8

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			3.00	4.00	5.00	
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-15,254	ADMINISTRATIVE & GENERAL	5.00		0 32.00
33.00 HAF NET FEE EXPENSE	A	147,579	ADMINISTRATIVE & GENERAL	5.00		9 33.00
33.01 CAH HIT ADJ DEPR CARYFRWD 2013	A	-76,964	ADMINISTRATIVE & GENERAL	5.00		0 33.01
33.02 CAH HIT ADJ DEPR CARYFRWD 2012	A	-106,969	ADMINISTRATIVE & GENERAL	5.00		0 33.02
34.00 MISCELLANEOUS REVENUE	B	-911	ADMINISTRATIVE & GENERAL	5.00		0 34.00
35.00 SPEECH THERAPY CONTRACTED	B	-10,976	SPEECH PATHOLOGY	68.00		0 35.00
36.00 NON-PATIENT EMS REVENUE	B	-300	AMBULANCE SERVICES	95.00		0 36.00
37.00 HOUSEKEEPING SUPPLIES	B	-27	HOUSEKEEPING	9.00		0 37.00
38.00 PHARMACY EMPLOYEE RX PURCHASES	B	-277,569	DRUGS CHARGED TO PATIENTS	73.00		0 38.00
40.00 SELF INSURANCE	A	-560,683	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 40.00
41.00 LOBBY % OF DUES & SUBSCRIPTIONS	A	-2,870	ADMINISTRATIVE & GENERAL	5.00		0 41.00
44.01 MARKETING	A	18	PHYSICAL THERAPY	66.00		0 44.01
44.02 MARKETING	A	-100	LIFEBRIDGE SENIOR CARE	90.01		0 44.02
47.00 ADD-BACK OF DEMOLISHED ASSET DEPREC	A	17,940	CAP REL COSTS-BLDG & FIXT	1.00		9 47.00
48.00 ADD-BACK OF DEMOLITION COSTS	A	4,125	ADMINISTRATIVE & GENERAL	5.00		0 48.00
49.00 NOT REALTED TO PATIENT CARE	A	-97	PHYSICAL THERAPY	66.00		0 49.00
49.01 TELEMETRY MONITORING EXPENSE	A	11,569	ADULTS & PEDIATRICS	30.00		0 49.01
49.02 MEDICAL DIRECTOR ADDITIONAL A/P	A	1,050	ADULTS & PEDIATRICS	30.00		0 49.02
49.03 ON-CALL PROF TIME	A	-110,867	ANESTHESIOLOGY	53.00		0 49.03
49.04 GROSS-UP ANESTHESIA EXPENSE FOR A/R	A	290,123	ANESTHESIOLOGY	53.00		0 49.04
49.05 CHARITY CONTRIBUTIONS	A	-822	ADMINISTRATIVE & GENERAL	5.00		0 49.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,294,350				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: 151323

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

Worksheet A-8-1

Date/Time Prepared:  
5/21/2015 9:27 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4,970,901	4,750,000 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	1,922,015 2.00
3.00	0.00			0	0 3.00
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.			4,970,901	6,672,015 5.00

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

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

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

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

6.00	B		0.00	PARKVIEW HEALTH SYSTEM, INC.	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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: 151323

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

Worksheet A-8-1

Date/Time Prepared:  
5/21/2015 9:27 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	220,901	0		1.00
2.00	-1,922,015	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1,701,114			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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 requested 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: 151323

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

Worksheet A-8-2

Date/Time Prepared:  
5/21/2015 9:27 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	AGGREGATE-ANESTHESIOLOGY	411,453	379,951	31,502	0	0	1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	431,525	431,525	0	0	0	2.00
3.00	91.00	DR. A	30,000	0	30,000	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1,394,066	882,359	511,707	0	0	4.00
5.00	30.00	DR. B	7,789	0	7,789	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			2,274,833	1,693,835	580,998	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	91.00	DR. A	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	DR. B	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	379,951	1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	431,525	2.00
3.00	91.00	DR. A	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	882,359	4.00
5.00	30.00	DR. B	0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,693,835	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
		0	1.00	1.01	2.00	2.01	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,265,469	1,265,469			1.00
1.01	00101	EMS WEST STATION	16,040	0	16,040		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	511,952			511,952	2.00
2.01	00201	EMS WEST STATION EQUIP.	19,818			0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,461,582	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,417,389	228,709	0	92,525	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	967,083	71,878	0	29,078	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,592	4,110	0	1,663	8.00
9.00	00900	HOUSEKEEPING	187,980	13,450	0	5,441	9.00
10.00	01000	DIETARY	235,105	53,961	0	21,830	10.00
11.00	01100	CAFETERIA	142,417	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	275,530	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-21,920	25,632	0	10,370	14.00
15.00	01500	PHARMACY	491,052	22,059	0	8,924	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,353	0	1,761	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	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	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,148,428	284,813	0	115,224	30.00
43.00	04300	NURSERY	141,774	4,288	0	1,735	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,029,831	162,338	0	65,675	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	414,989	20,272	0	8,201	52.00
53.00	05300	ANESTHESIOLOGY	31,423	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	952,759	80,454	0	32,548	54.00
60.00	06000	LABORATORY	842,407	32,097	0	12,985	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	307,085	16,796	0	6,795	65.00
66.00	06600	PHYSICAL THERAPY	322,990	53,799	0	21,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,027	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	52,526	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,325	1,511	0	611	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	315,541	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,143	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	741,081	0	0	0	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	5,713	0	0	0	90.00
90.01	09001	LIFEBIDGE SENIOR CARE	205,851	14,782	0	5,980	90.01
91.00	09100	EMERGENCY	1,251,551	112,422	0	45,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	1,200,641	0	16,040	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,306,174	1,207,724	16,040	488,591	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,342	3,622	0	1,465	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,365	54,123	0	21,896	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01	07951	FOUNDATION	24,861	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	91,340	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	194.04
194.06	07953	SHI PSHAWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
	0	1.00	1.01	2.00	2.01	
202.00   TOTAL (sum lines 118-201)	23,431,082	1,265,469	16,040	511,952	19,818	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		4.00	4A	5.00	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	EMS WEST STATION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	EMS WEST STATION EQUIP.					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,461,582				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,082,161	7,820,784	7,820,784		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	91,961	1,160,000	581,162	0	1,741,162
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,365	41,766	0	7,416
9.00	00900	HOUSEKEEPING	58,316	265,187	132,859	0	24,270
10.00	01000	DIETARY	46,866	357,762	179,239	0	97,374
11.00	01100	CAFETERIA	68,488	210,905	105,664	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	99,204	374,734	187,742	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,082	7,055	0	46,254
15.00	01500	PHARMACY	145,852	667,887	334,613	0	39,806
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,114	3,063	0	7,856
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	344,893	1,893,358	948,570	0	513,957
43.00	04300	NURSERY	47,015	194,812	97,601	0	7,738
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	256,633	1,514,477	758,756	0	292,944
52.00	05200	DELIVERY ROOM & LABOR ROOM	137,617	581,079	291,122	0	36,581
53.00	05300	ANESTHESIOLOGY	0	31,423	15,743	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,063	1,270,824	636,685	0	145,182
60.00	06000	LABORATORY	0	887,489	444,634	0	57,921
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	102,785	433,461	217,165	0	30,309
66.00	06600	PHYSICAL THERAPY	121,647	520,200	260,621	0	97,081
67.00	06700	OCCUPATIONAL THERAPY	32,218	117,245	58,740	0	0
68.00	06800	SPEECH PATHOLOGY	22,400	74,926	37,538	0	0
69.00	06900	ELECTROCARDIOLOGY	0	3,447	1,727	0	2,726
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	315,541	158,087	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	208,143	104,280	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	741,081	371,283	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	1,891	7,604	3,810	0	0
90.01	09001	LIFEBRIDGE SENIOR CARE	39,253	265,866	133,199	0	26,674
91.00	09100	EMERGENCY	233,435	1,642,889	823,091	0	202,868
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	313,762	1,550,261	776,684	0	0
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,451,460	23,214,946	7,712,499	0	1,636,957
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,429	6,227	0	6,537
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	77,384	38,770	0	97,668
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0
194.01	07951	FOUNDATION	6,166	31,027	15,545	0	0
194.03	07952	COMMUNITY & VOLUNTEER SVCS	3,956	95,296	47,743	0	0
194.04	07954	ER PHYSICIAN	0	0	0	0	0
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,461,582	23,431,082	7,820,784	0	1,741,162

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		8.00	9.00	10.00	11.00	12.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800	132,547					8.00
9.00	00900	0	422,316				9.00
10.00	01000	742	24,056	659,173			10.00
11.00	01100	0	0	0	316,569		11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	17,149	0	13.00
14.00	01400	0	11,427	0	0	0	14.00
15.00	01500	0	9,834	0	16,514	0	15.00
16.00	01600	0	1,941	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	40,825	126,970	659,173	67,893	0	30.00
43.00	04300	2,227	1,912	0	7,956	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	26,059	72,370	0	46,466	0	50.00
52.00	05200	6,561	9,037	0	23,300	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	12,963	35,866	0	36,905	0	54.00
60.00	06000	0	14,309	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	954	7,488	0	19,857	0	65.00
66.00	06600	5,130	23,983	0	22,564	0	66.00
67.00	06700	1,365	0	0	5,349	0	67.00
68.00	06800	941	0	0	2,541	0	68.00
69.00	06900	0	673	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	401	0	90.00
90.01	09001	0	6,590	0	7,755	0	90.01
91.00	09100	26,284	50,117	0	41,919	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	5,673	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1-117)		129,724	396,573	659,173	316,569	0	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	1,615	0	0	0	190.00
192.00	19200	2,823	24,128	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07952	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.06	07953	0	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		132,547	422,316	659,173	316,569	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300	579,625					13.00
14.00	01400	0	78,818				14.00
15.00	01500	0	2,185	1,070,839			15.00
16.00	01600	0	0	0	18,974		16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	240,082	5,773	69	4,049	0	30.00
43.00	04300	25,061	628	13	877	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	129,919	15,189	2,355	1,051	0	50.00
52.00	05200	67,618	1,839	40	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	1,883	5,975	3,157	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	422	0	0	0	65.00
66.00	06600	0	324	464	3,070	0	66.00
67.00	06700	0	86	122	666	0	67.00
68.00	06800	0	60	86	32	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	22,799	0	0	0	71.00
72.00	07200	0	14,987	0	0	0	72.00
73.00	07300	0	0	1,040,953	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	52	0	0	0	90.01
91.00	09100	116,945	4,525	2,315	6,072	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	7,957	18,447	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		579,625	78,709	1,070,839	18,974	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	28	0	0	0	190.00
192.00	19200	0	55	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	8	0	0	0	194.01
194.03	07952	0	18	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.06	07953	0	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		579,625	78,818	1,070,839	18,974	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED PRGM		
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
			19.00	20.00			21.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00	
1.01 00101 EMS WEST STATION						1.01	
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00	
2.01 00201 EMS WEST STATION EQUIP.						2.01	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00	
5.00 00500 ADMINISTRATIVE & GENERAL						5.00	
6.00 00600 MAINTENANCE & REPAIRS						6.00	
7.00 00700 OPERATION OF PLANT						7.00	
8.00 00800 LAUNDRY & LINEN SERVICE						8.00	
9.00 00900 HOUSEKEEPING						9.00	
10.00 01000 DIETARY						10.00	
11.00 01100 CAFETERIA						11.00	
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	0					19.00	
20.00 02000 NURSING SCHOOL	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	0	0		22.00	
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
43.00 04300 NURSERY	0	0	0	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	
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 LI THOTRI PSY	0	0	0	0	0	76.99	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 09001 LIFEBRIDGE SENIOR CARE	0	0	0	0	0	90.01	
91.00 09100 EMERGENCY	0	0	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00	
99.10 09910 CORF	0	0	0	0	0	99.10	
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20	
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30	
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300 INTEREST EXPENSE						113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)					0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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 OCCUPATIONAL HEALTH	0	0	0	0	0	194.00	
194.01 07951 FOUNDATION	0	0	0	0	0	194.01	
194.03 07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	0	0	194.03	
194.04 07954 ER PHYSICIAN	0	0	0	0	0	194.04	
194.06 07953 SHIPHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194.06	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers					0	201.00
202.00	TOTAL (sum lines 118-201)					0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
1.01	00101				1.01
2.00	00200				2.00
2.01	00201				2.01
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
19.00	01900				19.00
20.00	02000				20.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	4,500,719	0	4,500,719	30.00
43.00	04300	338,825	0	338,825	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	2,859,586	0	2,859,586	50.00
52.00	05200	1,017,177	0	1,017,177	52.00
53.00	05300	47,166	0	47,166	53.00
54.00	05400	2,149,440	0	2,149,440	54.00
60.00	06000	1,404,353	0	1,404,353	60.00
62.30	06250	0	0	0	62.30
65.00	06500	709,656	0	709,656	65.00
66.00	06600	933,437	0	933,437	66.00
67.00	06700	183,573	0	183,573	67.00
68.00	06800	116,124	0	116,124	68.00
69.00	06900	8,573	0	8,573	69.00
71.00	07100	496,427	0	496,427	71.00
72.00	07200	327,410	0	327,410	72.00
73.00	07300	2,153,317	0	2,153,317	73.00
76.97	07697	0	0	0	76.97
76.98	07698	0	0	0	76.98
76.99	07699	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	11,815	0	11,815	90.00
90.01	09001	440,136	0	440,136	90.01
91.00	09100	2,917,025	0	2,917,025	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	2,359,022	0	2,359,022	95.00
99.10	09910	0	0	0	99.10
99.20	09920	0	0	0	99.20
99.30	09930	0	0	0	99.30
99.40	09940	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		22,973,781	0	22,973,781	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	26,836	0	26,836	190.00
192.00	19200	240,828	0	240,828	192.00
194.00	07950	0	0	0	194.00
194.01	07951	46,580	0	46,580	194.01
194.03	07952	143,057	0	143,057	194.03
194.04	07954	0	0	0	194.04
194.06	07953	0	0	0	194.06
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		23,431,082	0	23,431,082	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
			0	1.00	1.01	2.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	EMS WEST STATION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	EMS WEST STATION EQUIP.					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	228,709	0	92,525	5.00
6.00	00600	MAINTENANCE & REPAIRS	971,920	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	71,878	0	29,078	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,110	0	1,663	8.00
9.00	00900	HOUSEKEEPING	0	13,450	0	5,441	9.00
10.00	01000	DIETARY	0	53,961	0	21,830	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	25,632	0	10,370	14.00
15.00	01500	PHARMACY	0	22,059	0	8,924	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,353	0	1,761	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	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	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	284,813	0	115,224	30.00
43.00	04300	NURSERY	0	4,288	0	1,735	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	162,338	0	65,675	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	20,272	0	8,201	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	80,454	0	32,548	54.00
60.00	06000	LABORATORY	0	32,097	0	12,985	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	16,796	0	6,795	65.00
66.00	06600	PHYSICAL THERAPY	0	53,799	0	21,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,511	0	611	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	LIFEBIDGE SENIOR CARE	0	14,782	0	5,980	90.01
91.00	09100	EMERGENCY	0	112,422	0	45,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	16,040	0	19,818
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	971,920	1,207,724	16,040	488,591	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,622	0	1,465	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	54,123	0	21,896	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	194.04
194.06	07953	SHISHEWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118-201)	971,920	1,265,469	16,040	511,952	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		2A	4.00	5.00	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	EMS WEST STATION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	EMS WEST STATION EQUIP.					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	321,234	0	321,234		5.00
6.00	00600	MAINTENANCE & REPAIRS	971,920	0	0	971,920	6.00
7.00	00700	OPERATION OF PLANT	100,956	0	23,870	0	124,826
8.00	00800	LAUNDRY & LINEN SERVICE	5,773	0	1,715	0	532
9.00	00900	HOUSEKEEPING	18,891	0	5,457	0	1,740
10.00	01000	DIETARY	75,791	0	7,362	0	6,981
11.00	01100	CAFETERIA	0	0	4,340	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	7,711	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	36,002	0	290	0	3,316
15.00	01500	PHARMACY	30,983	0	13,744	0	2,854
16.00	01600	MEDICAL RECORDS & LIBRARY	6,114	0	126	0	563
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	400,037	0	38,968	0	36,845
43.00	04300	NURSERY	6,023	0	4,009	0	555
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	228,013	0	31,165	0	21,002
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,473	0	11,957	0	2,623
53.00	05300	ANESTHESIOLOGY	0	0	647	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,002	0	26,151	0	10,408
60.00	06000	LABORATORY	45,082	0	18,263	0	4,152
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	23,591	0	8,920	0	2,173
66.00	06600	PHYSICAL THERAPY	75,563	0	10,705	0	6,960
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,413	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	1,542	0	0
69.00	06900	ELECTROCARDIOLOGY	2,122	0	71	0	195
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,493	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,283	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	15,250	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	156	0	0
90.01	09001	LIFEBRIDGE SENIOR CARE	20,762	0	5,471	0	1,912
91.00	09100	EMERGENCY	157,903	0	33,807	0	14,544
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	35,858	0	31,901	0	0
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,704,093	0	316,787	0	117,355
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,087	0	256	0	469
192.00	19200	PHYSICIANS' PRIVATE OFFICES	76,019	0	1,592	0	7,002
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0
194.01	07951	FOUNDATION	0	0	638	0	0
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	1,961	0	0
194.04	07954	ER PHYSICIAN	0	0	0	0	0
194.06	07953	SHI PSHEWANA RADIOLOGY AND LAB	0	0	0	0	0
200.00		Cross Foot Adjustments	0				200.00
201.00		Negative Cost Centers	0		0		0
202.00		TOTAL (sum lines 118-201)	2,785,199	0	321,234	0	124,826

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151323		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/21/2015 9:27 am	
Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		8.00	9.00	10.00	11.00	12.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	EMS WEST STATION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	EMS WEST STATION EQUIP.					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,020				8.00
9.00	00900	HOUSEKEEPING	0	26,088			9.00
10.00	01000	DIETARY	45	1,486	91,665		10.00
11.00	01100	CAFETERIA	0	0	0	4,340	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	235	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	706	0	0	14.00
15.00	01500	PHARMACY	0	607	0	226	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	120	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	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	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,470	7,842	91,665	933	30.00
43.00	04300	NURSERY	135	118	0	109	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,577	4,471	0	637	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	397	558	0	319	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	784	2,216	0	506	54.00
60.00	06000	LABORATORY	0	884	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	58	463	0	272	65.00
66.00	06600	PHYSICAL THERAPY	310	1,482	0	309	66.00
67.00	06700	OCCUPATIONAL THERAPY	83	0	0	73	67.00
68.00	06800	SPEECH PATHOLOGY	57	0	0	35	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	5	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	407	0	106	90.01
91.00	09100	EMERGENCY	1,590	3,096	0	575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	343	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,849	24,498	91,665	4,340	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	100	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	171	1,490	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	194.04
194.06	07953	SHI PSEWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,020	26,088	91,665	4,340	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300	7,946					13.00
14.00	01400	0	31,542				14.00
15.00	01500	0	874	49,288			15.00
16.00	01600	0	0	0	6,923		16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,291	2,310	3	1,477	0	30.00
43.00	04300	344	251	1	320	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,781	6,078	108	384	0	50.00
52.00	05200	927	736	2	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	754	275	1,152	0	54.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	169	0	0	0	65.00
66.00	06600	0	130	21	1,120	0	66.00
67.00	06700	0	34	6	243	0	67.00
68.00	06800	0	24	4	12	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	9,125	0	0	0	71.00
72.00	07200	0	5,998	0	0	0	72.00
73.00	07300	0	0	47,912	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	21	0	0	0	90.01
91.00	09100	1,603	1,811	107	2,215	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	3,184	849	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		7,946	31,499	49,288	6,923	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	11	0	0	0	190.00
192.00	19200	0	22	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	3	0	0	0	194.01
194.03	07952	0	7	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.06	07953	0	0	0	0	0	194.06
200.00							200.00
201.00		0	8,772	0	0	0	201.00
202.00		7,946	40,314	49,288	6,923	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			19.00	20.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	EMS WEST STATION					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	EMS WEST STATION EQUIP.					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
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	0				19.00
20.00 02000	NURSING SCHOOL		0			20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV			0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV				0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)					0 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS					30.00
43.00 04300	NURSERY					43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM					50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM					52.00
53.00 05300	ANESTHESIOLOGY					53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC					54.00
60.00 06000	LABORATORY					60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65.00 06500	RESPIRATORY THERAPY					65.00
66.00 06600	PHYSICAL THERAPY					66.00
67.00 06700	OCCUPATIONAL THERAPY					67.00
68.00 06800	SPEECH PATHOLOGY					68.00
69.00 06900	ELECTROCARDIOLOGY					69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT					71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS					72.00
73.00 07300	DRUGS CHARGED TO PATIENTS					73.00
76.97 07697	CARDIAC REHABILITATION					76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99 07699	LITHOTRIPSY					76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC					90.00
90.01 09001	LIFEBRIDGE SENIOR CARE					90.01
91.00 09100	EMERGENCY					91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES					95.00
99.10 09910	CORF					99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY					99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY					99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES					192.00
194.00 07950	OCCUPATIONAL HEALTH					194.00
194.01 07951	FOUNDATION					194.01
194.03 07952	COMMUNITY & VOLUNTEER SVCS					194.03
194.04 07954	ER PHYSICIAN					194.04
194.06 07953	SHI PSHEWANA RADIOLOGY AND LAB					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	0	0	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/21/2015 9:27 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
1.01	00101				1.01
2.00	00200				2.00
2.01	00201				2.01
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
19.00	01900				19.00
20.00	02000				20.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	585,841	0	585,841	30.00
43.00	04300	11,865	0	11,865	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	295,216	0	295,216	50.00
52.00	05200	45,992	0	45,992	52.00
53.00	05300	647	0	647	53.00
54.00	05400	155,248	0	155,248	54.00
60.00	06000	68,381	0	68,381	60.00
62.30	06250	0	0	0	62.30
65.00	06500	35,646	0	35,646	65.00
66.00	06600	96,600	0	96,600	66.00
67.00	06700	2,852	0	2,852	67.00
68.00	06800	1,674	0	1,674	68.00
69.00	06900	2,430	0	2,430	69.00
71.00	07100	15,618	0	15,618	71.00
72.00	07200	10,281	0	10,281	72.00
73.00	07300	63,162	0	63,162	73.00
76.97	07697	0	0	0	76.97
76.98	07698	0	0	0	76.98
76.99	07699	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	161	0	161	90.00
90.01	09001	28,679	0	28,679	90.01
91.00	09100	217,251	0	217,251	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	72,135	0	72,135	95.00
99.10	09910	0	0	0	99.10
99.20	09920	0	0	0	99.20
99.30	09930	0	0	0	99.30
99.40	09940	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		1,709,679	0	1,709,679	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	5,923	0	5,923	190.00
192.00	19200	86,296	0	86,296	192.00
194.00	07950	0	0	0	194.00
194.01	07951	641	0	641	194.01
194.03	07952	1,968	0	1,968	194.03
194.04	07954	0	0	0	194.04
194.06	07953	0	0	0	194.06
200.00		0	0	0	200.00
201.00		8,772	0	8,772	201.00
202.00		1,813,279	0	1,813,279	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		BLDG & FIXT (SQUARE FEET)	EMS WEST STATION (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMS WEST STATION EQUIP. (SQUARE FEET)		
		1.00	1.01	2.00	2.01		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT	77,906				1.00
1.01	00101	EMS WEST STATION	0	9,760			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			77,906		2.00
2.01	00201	EMS WEST STATION EQUIP.			0	9,760	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,080	0	14,080	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,425	0	4,425	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253	0	253	0	8.00
9.00	00900	HOUSEKEEPING	828	0	828	0	9.00
10.00	01000	DIETARY	3,322	0	3,322	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,578	0	1,578	0	14.00
15.00	01500	PHARMACY	1,358	0	1,358	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268	0	268	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	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	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	17,534	0	17,534	0	30.00
43.00	04300	NURSERY	264	0	264	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	9,994	0	9,994	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,248	0	1,248	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,953	0	4,953	0	54.00
60.00	06000	LABORATORY	1,976	0	1,976	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,034	0	1,034	0	65.00
66.00	06600	PHYSICAL THERAPY	3,312	0	3,312	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	93	0	93	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	LIFEBIDGE SENIOR CARE	910	0	910	0	90.01
91.00	09100	EMERGENCY	6,921	0	6,921	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	9,760	0	9,760	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,351	9,760	74,351	9,760	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	223	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,332	0	3,332	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	194.04
194.06	07953	SHI PSEWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		BLDG & FIXT (SQUARE FEET)	EMS WEST STATION (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMS WEST STATION EQUIP. (SQUARE FEET)		
		1.00	1.01	2.00	2.01		
202.00	Cost to be allocated (per Wkst. B, Part I)	1,265,469	16,040	511,952	19,818	3,461,582	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.243537	1.643443	6.571407	2.030533	0.360873	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A	5.00	6.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	EMS WEST STATION					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	EMS WEST STATION EQUIP.					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,820,784	15,610,298			5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	1,160,000	0	59,401	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,365	0	253	10,000
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,365	0	253	8.00
9.00	00900	HOUSEKEEPING	0	265,187	0	828	0
9.00	00900	HOUSEKEEPING	0	265,187	0	828	9.00
10.00	01000	DIETARY	0	357,762	0	3,322	56
10.00	01000	DIETARY	0	357,762	0	3,322	10.00
11.00	01100	CAFETERIA	0	210,905	0	0	0
11.00	01100	CAFETERIA	0	210,905	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	374,734	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	374,734	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,082	0	1,578	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,082	0	1,578	14.00
15.00	01500	PHARMACY	0	667,887	0	1,358	0
15.00	01500	PHARMACY	0	667,887	0	1,358	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,114	0	268	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,114	0	268	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0
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	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	1,893,358	0	17,534	3,080
30.00	03000	ADULTS & PEDIATRICS	0	1,893,358	0	17,534	30.00
43.00	04300	NURSERY	0	194,812	0	264	168
43.00	04300	NURSERY	0	194,812	0	264	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	1,514,477	0	9,994	1,966
50.00	05000	OPERATING ROOM	0	1,514,477	0	9,994	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	581,079	0	1,248	495
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	581,079	0	1,248	52.00
53.00	05300	ANESTHESIOLOGY	0	31,423	0	0	0
53.00	05300	ANESTHESIOLOGY	0	31,423	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,270,824	0	4,953	978
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,270,824	0	4,953	54.00
60.00	06000	LABORATORY	0	887,489	0	1,976	0
60.00	06000	LABORATORY	0	887,489	0	1,976	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	433,461	0	1,034	72
65.00	06500	RESPIRATORY THERAPY	0	433,461	0	1,034	65.00
66.00	06600	PHYSICAL THERAPY	0	520,200	0	3,312	387
66.00	06600	PHYSICAL THERAPY	0	520,200	0	3,312	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	117,245	0	0	103
67.00	06700	OCCUPATIONAL THERAPY	0	117,245	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	74,926	0	0	71
68.00	06800	SPEECH PATHOLOGY	0	74,926	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,447	0	93	0
69.00	06900	ELECTROCARDIOLOGY	0	3,447	0	93	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	315,541	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	315,541	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	208,143	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	208,143	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	741,081	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	741,081	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	7,604	0	0	0
90.00	09000	CLINIC	0	7,604	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	265,866	0	910	0
90.01	09001	LIFEBRIDGE SENIOR CARE	0	265,866	0	910	90.01
91.00	09100	EMERGENCY	0	1,642,889	0	6,921	1,983
91.00	09100	EMERGENCY	0	1,642,889	0	6,921	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	1,550,261	0	0	428
95.00	09500	AMBULANCE SERVICES	0	1,550,261	0	0	95.00
99.10	09910	CORF	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,820,784	15,394,162	0	55,846	9,787
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,820,784	15,394,162	0	55,846	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,429	0	223	0
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,429	0	223	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	77,384	0	3,332	213
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	77,384	0	3,332	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	31,027	0	0	0
194.01	07951	FOUNDATION	0	31,027	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	95,296	0	0	0
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	95,296	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0
194.04	07954	ER PHYSICIAN	0	0	0	0	194.04
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0
194.06	07953	SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00		Cross Foot Adjustments					
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		7,820,784	0	1,741,162	132,547
202.00		Cost to be allocated (per Wkst. B, Part I)		7,820,784	0	1,741,162	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.501002	0.000000	29.311998	13.254700
203.00		Unit cost multiplier (Wkst. B, Part I)		0.501002	0.000000	29.311998	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A	5.00	6.00	7.00	8.00	
204.00	Cost to be allocated (per Wkst. B, Part II)		321,234	971,920	124,826	8,020	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.020578	0.000000	2.101412	0.802000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	
			9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	58,320					9.00
10.00	01000	DIETARY	3,322	27,552				10.00
11.00	01100	CAFETERIA	0	0	9,470			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	513	0	114,369	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,578	0	0	0	0	14.00
15.00	01500	PHARMACY	1,358	0	494	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	17,534	27,552	2,031	0	47,372	30.00
43.00	04300	NURSERY	264	0	238	0	4,945	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	9,994	0	1,390	0	25,635	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,248	0	697	0	13,342	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,953	0	1,104	0	0	54.00
60.00	06000	LABORATORY	1,976	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	1,034	0	594	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,312	0	675	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	160	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	76	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	93	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	12	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	910	0	232	0	0	90.01
91.00	09100	EMERGENCY	6,921	0	1,254	0	23,075	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,765	27,552	9,470	0	114,369	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,332	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHI PSEWANA RADIOLOGY AND LAB	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)	422,316	659,173	316,569	0	579,625	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		9.00	10.00	11.00	12.00	13.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	7.241358	23.924688	33.428617	0.000000	5.068025	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	26,088	91,665	4,340	0	7,946	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.447325	3.326982	0.458289	0.000000	0.069477	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	EMS WEST STATION						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	EMS WEST STATION EQUIP.						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,094,620					14.00
15.00	01500	PHARMACY	30,339	325,130				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	10,000			16.00
17.00	01700	SOCIAL SERVICE	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	80,175	21	2,134	0		30.00
43.00	04300	NURSERY	8,724	4	462	0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	210,940	715	554	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,538	12	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,155	1,814	1,664	0	0	54.00
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	5,855	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,496	141	1,618	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,191	37	351	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	827	26	17	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	316,643	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,143	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	316,056	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	3	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	725	0	0	0	0	90.01
91.00	09100	EMERGENCY	62,841	703	3,200	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	110,510	5,601	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,093,105	325,130	10,000	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	387	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	770	0	0	0	0	192.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	111	0	0	0	0	194.01
194.03	07952	COMMUNITY & VOLUNTEER SVCS	247	0	0	0	0	194.03
194.04	07954	ER PHYSICIAN	0	0	0	0	0	194.04
194.06	07953	SHI PSHEWANA RADIOLOGY AND LAB	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)	78,818	1,070,839	18,974	0	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	19.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.072005	3.293572	1.897400	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	40,314	49,288	6,923	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.028815	0.151595	0.692300	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
		20.00	21.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	EMS WEST STATION					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	EMS WEST STATION EQUIP.					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
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	0				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV		0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV			0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)				0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
43.00 04300	NURSERY	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97 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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	LIFEBIDGE SENIOR CARE	0	0	0	0	90.01
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OCCUPATIONAL HEALTH	0	0	0	0	194.00
194.01 07951	FOUNDATION	0	0	0	0	194.01
194.03 07952	COMMUNITY & VOLUNTEER SVCS	0	0	0	0	194.03
194.04 07954	ER PHYSICIAN	0	0	0	0	194.04
194.06 07953	SHI PSEWANA RADIOLOGY AND LAB	0	0	0	0	194.06
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151323

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

Worksheet B-1

Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
		20.00	21.00			
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	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	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	4,500,719		4,500,719	0	0	30.00
43.00	04300 NURSERY	338,825		338,825	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,859,586		2,859,586	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,017,177		1,017,177	0	0	52.00
53.00	05300 ANESTHESIOLOGY	47,166		47,166	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,149,440		2,149,440	0	0	54.00
60.00	06000 LABORATORY	1,404,353		1,404,353	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	709,656	0	709,656	0	0	65.00
66.00	06600 PHYSICAL THERAPY	933,437	0	933,437	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	183,573	0	183,573	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	116,124	0	116,124	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	8,573		8,573	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	496,427		496,427	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	327,410		327,410	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,153,317		2,153,317	0	0	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 LI THOTRI PSY	0		0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	11,815		11,815	0	0	90.00
90.01	09001 LIFEBRIDGE SENIOR CARE	440,136		440,136	0	0	90.01
91.00	09100 EMERGENCY	2,917,025		2,917,025	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	827,199		827,199	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	2,359,022		2,359,022	0	0	95.00
99.10	09910 CORF	0		0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	23,800,980	0	23,800,980	0	0	200.00
201.00	Less Observation Beds	827,199		827,199			201.00
202.00	Total (see instructions)	22,973,781	0	22,973,781	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	4,365,246		4,365,246		30.00
43.00	04300	NURSERY	622,796		622,796		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,387,013	9,623,299	13,010,312	0.219794	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,822,289	0	1,822,289	0.558186	52.00
53.00	05300	ANESTHESIOLOGY	332,547	923,211	1,255,758	0.037560	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,115,018	17,295,254	18,410,272	0.116752	54.00
60.00	06000	LABORATORY	1,034,922	4,052,910	5,087,832	0.276022	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	441,245	1,235,189	1,676,434	0.423313	65.00
66.00	06600	PHYSICAL THERAPY	278,244	1,210,865	1,489,109	0.626843	66.00
67.00	06700	OCCUPATIONAL THERAPY	234,997	297,281	532,278	0.344882	67.00
68.00	06800	SPEECH PATHOLOGY	21,713	61,216	82,929	1.400282	68.00
69.00	06900	ELECTROCARDIOLOGY	125,832	211,907	337,739	0.025384	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	558,261	1,264,317	1,822,578	0.272376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	807,599	221,589	1,029,188	0.318125	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,242,150	3,679,185	5,921,335	0.363654	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	7,291	7,291	1.620491	90.00
90.01	09001	LI FEBRI DGE SENIOR CARE	0	189,650	189,650	2.320780	90.01
91.00	09100	EMERGENCY	299,184	8,535,874	8,835,058	0.330165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	810,728	810,728	1.020316	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	3,411,770	3,411,770	0.691436	95.00
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	17,689,056	53,031,536	70,720,592		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	17,689,056	53,031,536	70,720,592		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/21/2015 9:27 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 LI FEBRIDGE SENIOR CARE	0.000000		90.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY			99.40
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151323		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/21/2015 9:27 am	
		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		4,500,719		0	4,500,719	30.00
43.00	04300 NURSERY		338,825		0	338,825	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		2,859,586		0	2,859,586	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,017,177		0	1,017,177	52.00
53.00	05300 ANESTHESIOLOGY		47,166		0	47,166	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,149,440		0	2,149,440	54.00
60.00	06000 LABORATORY		1,404,353		0	1,404,353	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0		0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	709,656		0	709,656	65.00
66.00	06600 PHYSICAL THERAPY	0	933,437		0	933,437	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	183,573		0	183,573	67.00
68.00	06800 SPEECH PATHOLOGY	0	116,124		0	116,124	68.00
69.00	06900 ELECTROCARDIOLOGY		8,573		0	8,573	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		496,427		0	496,427	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		327,410		0	327,410	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,153,317		0	2,153,317	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 LI THOTRI PSY		0		0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC		11,815		0	11,815	90.00
90.01	09001 LIFEBRIDGE SENIOR CARE		440,136		0	440,136	90.01
91.00	09100 EMERGENCY		2,917,025		0	2,917,025	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		827,199		0	827,199	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		2,359,022		0	2,359,022	95.00
99.10	09910 CORF		0		0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY		0		0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY		0		0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY		0		0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)		23,800,980	0	0	23,800,980	200.00
201.00	Less Observation Beds		827,199			827,199	201.00
202.00	Total (see instructions)		22,973,781	0	0	22,973,781	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	4,365,246		4,365,246		30.00
43.00	04300	NURSERY	622,796		622,796		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,387,013	9,623,299	13,010,312	0.219794	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,822,289	0	1,822,289	0.558186	52.00
53.00	05300	ANESTHESIOLOGY	332,547	923,211	1,255,758	0.037560	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,115,018	17,295,254	18,410,272	0.116752	54.00
60.00	06000	LABORATORY	1,034,922	4,052,910	5,087,832	0.276022	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	441,245	1,235,189	1,676,434	0.423313	65.00
66.00	06600	PHYSICAL THERAPY	278,244	1,210,865	1,489,109	0.626843	66.00
67.00	06700	OCCUPATIONAL THERAPY	234,997	297,281	532,278	0.344882	67.00
68.00	06800	SPEECH PATHOLOGY	21,713	61,216	82,929	1.400282	68.00
69.00	06900	ELECTROCARDIOLOGY	125,832	211,907	337,739	0.025384	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	558,261	1,264,317	1,822,578	0.272376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	807,599	221,589	1,029,188	0.318125	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,242,150	3,679,185	5,921,335	0.363654	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	7,291	7,291	1.620491	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	189,650	189,650	2.320780	90.01
91.00	09100	EMERGENCY	299,184	8,535,874	8,835,058	0.330165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	810,728	810,728	1.020316	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	3,411,770	3,411,770	0.691436	95.00
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	17,689,056	53,031,536	70,720,592		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	17,689,056	53,031,536	70,720,592		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/21/2015 9:27 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.219794		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.558186		52.00
53.00	05300 ANESTHESIOLOGY	0.037560		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116752		54.00
60.00	06000 LABORATORY	0.276022		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.423313		65.00
66.00	06600 PHYSICAL THERAPY	0.626843		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.344882		67.00
68.00	06800 SPEECH PATHOLOGY	1.400282		68.00
69.00	06900 ELECTROCARDIOLOGY	0.025384		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.272376		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.318125		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.363654		73.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRIPSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1.620491		90.00
90.01	09001 LI FEBRILE SENIOR CARE	2.320780		90.01
91.00	09100 EMERGENCY	0.330165		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.020316		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.691436		95.00
99.10	09910 CORF			99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY			99.40
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 151323

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

Worksheet C Part II Date/Time Prepared: 5/21/2015 9:27 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,859,586	295,216	2,564,370	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,017,177	45,992	971,185	0	0	52.00
53.00	05300	ANESTHESIOLOGY	47,166	647	46,519	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,149,440	155,248	1,994,192	0	0	54.00
60.00	06000	LABORATORY	1,404,353	68,381	1,335,972	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	709,656	35,646	674,010	0	0	65.00
66.00	06600	PHYSICAL THERAPY	933,437	96,600	836,837	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	183,573	2,852	180,721	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	116,124	1,674	114,450	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,573	2,430	6,143	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	496,427	15,618	480,809	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	327,410	10,281	317,129	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,153,317	63,162	2,090,155	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	11,815	161	11,654	0	0	90.00
90.01	09001	LIFEBIDGE SENIOR CARE	440,136	28,679	411,457	0	0	90.01
91.00	09100	EMERGENCY	2,917,025	217,251	2,699,774	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	827,199	121,721	705,478	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	2,359,022	72,135	2,286,887	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	18,961,436	1,233,694	17,727,742	0	0	200.00
201.00		Less Observation Beds	827,199	121,721	705,478	0	0	201.00
202.00		Total (line 200 minus line 201)	18,134,237	1,111,973	17,022,264	0	0	202.00

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

Provider CCN: 151323

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

Worksheet C Part II Date/Time Prepared: 5/21/2015 9:27 am

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)	Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	2,859,586	13,010,312	0.219794		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,017,177	1,822,289	0.558186		52.00
53.00	05300 ANESTHESIOLOGY	47,166	1,255,758	0.037560		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,149,440	18,410,272	0.116752		54.00
60.00	06000 LABORATORY	1,404,353	5,087,832	0.276022		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	709,656	1,676,434	0.423313		65.00
66.00	06600 PHYSICAL THERAPY	933,437	1,489,109	0.626843		66.00
67.00	06700 OCCUPATIONAL THERAPY	183,573	532,278	0.344882		67.00
68.00	06800 SPEECH PATHOLOGY	116,124	82,929	1.400282		68.00
69.00	06900 ELECTROCARDIOLOGY	8,573	337,739	0.025384		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	496,427	1,822,578	0.272376		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	327,410	1,029,188	0.318125		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,153,317	5,921,335	0.363654		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 LI THOTRI PSY	0	0	0.000000		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	11,815	7,291	1.620491		90.00
90.01	09001 LIFEBIDGE SENIOR CARE	440,136	189,650	2.320780		90.01
91.00	09100 EMERGENCY	2,917,025	8,835,058	0.330165		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	827,199	810,728	1.020316		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	2,359,022	3,411,770	0.691436		95.00
99.10	09910 CORF	0	0	0.000000		99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0.000000		99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000		99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000		99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	18,961,436	65,732,550			200.00
201.00	Less Observation Beds	827,199	0			201.00
202.00	Total (line 200 minus line 201)	18,134,237	65,732,550			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/21/2015 9:27 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	295,216	13,010,312	0.022691	566,762	12,860	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	45,992	1,822,289	0.025239	6,299	159	52.00
53.00	05300 ANESTHESIOLOGY	647	1,255,758	0.000515	71,644	37	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	155,248	18,410,272	0.008433	347,266	2,928	54.00
60.00	06000 LABORATORY	68,381	5,087,832	0.013440	291,209	3,914	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	35,646	1,676,434	0.021263	184,482	3,923	65.00
66.00	06600 PHYSICAL THERAPY	96,600	1,489,109	0.064871	91,583	5,941	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,852	532,278	0.005358	77,096	413	67.00
68.00	06800 SPEECH PATHOLOGY	1,674	82,929	0.020186	11,872	240	68.00
69.00	06900 ELECTROCARDIOLOGY	2,430	337,739	0.007195	53,928	388	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,618	1,822,578	0.008569	136,285	1,168	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,281	1,029,188	0.009989	423,727	4,233	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63,162	5,921,335	0.010667	684,518	7,302	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 LI THOTRI PSY	0	0	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	161	7,291	0.022082	0	0	90.00
90.01	09001 LI FEBRI DGE SENIOR CARE	28,679	189,650	0.151221	0	0	90.01
91.00	09100 EMERGENCY	217,251	8,835,058	0.024590	30,601	752	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	121,721	810,728	0.150138	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,161,559	62,320,780		2,977,272	44,258	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	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	
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	
90.01	09001	LIFEBRI DGE SENIOR CARE	0	0	0	0	0	90.01	
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: 151323

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/21/2015 9:27 am

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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	13,010,312	0.000000	0.000000	566,762	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,822,289	0.000000	0.000000	6,299	52.00
53.00	05300 ANESTHESIOLOGY	0	1,255,758	0.000000	0.000000	71,644	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	18,410,272	0.000000	0.000000	347,266	54.00
60.00	06000 LABORATORY	0	5,087,832	0.000000	0.000000	291,209	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	1,676,434	0.000000	0.000000	184,482	65.00
66.00	06600 PHYSICAL THERAPY	0	1,489,109	0.000000	0.000000	91,583	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	532,278	0.000000	0.000000	77,096	67.00
68.00	06800 SPEECH PATHOLOGY	0	82,929	0.000000	0.000000	11,872	68.00
69.00	06900 ELECTROCARDIOLOGY	0	337,739	0.000000	0.000000	53,928	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,822,578	0.000000	0.000000	136,285	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,029,188	0.000000	0.000000	423,727	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,921,335	0.000000	0.000000	684,518	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 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	7,291	0.000000	0.000000	0	90.00
90.01	09001 LI FEBRI DGE SENIOR CARE	0	189,650	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	8,835,058	0.000000	0.000000	30,601	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	810,728	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	62,320,780			2,977,272	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
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 LI THOTRI PSY	0	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 LI FEBRI DGE SENIOR CARE	0	0	0		90.01
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/21/2015 9:27 am
	Title XVIII	Hospital	Cost

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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.219794	0	1,232,161	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.558186	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.037560	0	136,851	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.116752	0	3,808,974	0	0
60.00 06000 LABORATORY	0.276022	0	1,142,012	0	0
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.423313	0	374,249	0	0
66.00 06600 PHYSICAL THERAPY	0.626843	0	411,638	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.344882	0	80,537	0	0
68.00 06800 SPEECH PATHOLOGY	1.400282	0	16,074	0	0
69.00 06900 ELECTROCARDIOLOGY	0.025384	0	81,060	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.272376	0	160,484	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.318125	0	79,998	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.363654	0	1,141,751	0	0
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	1.620491	0	7,188	0	0
90.01 09001 LIFEBRIDGE SENIOR CARE	2.320780	0	125,748	0	0
91.00 09100 EMERGENCY	0.330165	0	1,940,827	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.020316	0	465,135	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	0.691436	0	0	0	95.00
200.00 Subtotal (see instructions)		0	11,204,687	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	11,204,687	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/21/2015 9:27 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	270,822	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	5,140	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	444,705	0		54.00
60.00 06000 LABORATORY	315,220	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	158,424	0		65.00
66.00 06600 PHYSICAL THERAPY	258,032	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	27,776	0		67.00
68.00 06800 SPEECH PATHOLOGY	22,508	0		68.00
69.00 06900 ELECTROCARDIOLOGY	2,058	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	43,712	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25,449	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	415,202	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 LI THOTRI PSY	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	11,648	0		90.00
90.01 09001 LI FEBRI DGE SENI OR CARE	291,833	0		90.01
91.00 09100 EMERGENCY	640,793	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART	474,585	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	3,407,907	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)	3,407,907	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151323 Component CCN: 15Z323	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/21/2015 9:27 am
Title XVIII		Swing Beds - SNF	Cost

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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.219794	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.558186	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.037560	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.116752	0	0	0	0
60.00 06000 LABORATORY	0.276022	0	0	0	0
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.423313	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.626843	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.344882	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	1.400282	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.025384	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.272376	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.318125	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.363654	0	0	0	0
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	1.620491	0	0	0	0
90.01 09001 LI FEBRI DGE SENIOR CARE	2.320780	0	0	0	0
91.00 09100 EMERGENCY	0.330165	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.020316	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	0.691436		0		95.00
200.00	Subtotal (see instructions)		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	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151323 Component CCN: 15Z323	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/21/2015 9:27 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
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 LI THOTRI PSY	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 LI FEBRI DGE SENI OR CARE	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	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	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151323		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/21/2015 9:27 am		
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	585,841	65,402	520,439	3,191	163.10	30.00	
43.00	NURSERY	11,865		11,865	593	20.01	43.00	
200.00	Total (Lines 30-199)	597,706		532,304	3,784		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	230	37,513					30.00
43.00	NURSERY	197	3,942					43.00
200.00	Total (Lines 30-199)	427	41,455					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/21/2015 9:27 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	295,216	13,010,312	0.022691	546,256	12,395	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	45,992	1,822,289	0.025239	404,210	10,202	52.00
53.00	05300 ANESTHESIOLOGY	647	1,255,758	0.000515	124,122	64	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	155,248	18,410,272	0.008433	108,140	912	54.00
60.00	06000 LABORATORY	68,381	5,087,832	0.013440	111,467	1,498	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	35,646	1,676,434	0.021263	32,123	683	65.00
66.00	06600 PHYSICAL THERAPY	96,600	1,489,109	0.064871	5,324	345	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,852	532,278	0.005358	2,764	15	67.00
68.00	06800 SPEECH PATHOLOGY	1,674	82,929	0.020186	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,430	337,739	0.007195	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,618	1,822,578	0.008569	61,941	531	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,281	1,029,188	0.009989	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63,162	5,921,335	0.010667	238,962	2,549	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 LI THOTRI PSY	0	0	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	161	7,291	0.022082	0	0	90.00
90.01	09001 LI FEBRI DGE SENIOR CARE	28,679	189,650	0.151221	0	0	90.01
91.00	09100 EMERGENCY	217,251	8,835,058	0.024590	58,709	1,444	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	121,720	810,728	0.150137	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,161,558	62,320,780		1,694,018	30,638	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151323		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/21/2015 9:27 am	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,191	0.00	230	0		30.00
43.00	04300	NURSERY	593	0.00	197	0		43.00
200.00		Total (lines 30-199)	3,784		427	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	LIFEBRIDGE SENIOR CARE	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	13,010,312	0.000000	0.000000	546,256	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,822,289	0.000000	0.000000	404,210	52.00
53.00	05300	ANESTHESIOLOGY	0	1,255,758	0.000000	0.000000	124,122	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,410,272	0.000000	0.000000	108,140	54.00
60.00	06000	LABORATORY	0	5,087,832	0.000000	0.000000	111,467	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,676,434	0.000000	0.000000	32,123	65.00
66.00	06600	PHYSICAL THERAPY	0	1,489,109	0.000000	0.000000	5,324	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	532,278	0.000000	0.000000	2,764	67.00
68.00	06800	SPEECH PATHOLOGY	0	82,929	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	337,739	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,822,578	0.000000	0.000000	61,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,029,188	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,921,335	0.000000	0.000000	238,962	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	7,291	0.000000	0.000000	0	90.00
90.01	09001	LI FEBRILE SENIOR CARE	0	189,650	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	8,835,058	0.000000	0.000000	58,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	810,728	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	62,320,780			1,694,018	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/21/2015 9:27 am

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		
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
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 LI THOTRI PSY	0	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 LI FEBRI DGE SENIOR CARE	0	0	0		90.01
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/21/2015 9:27 am
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.219794	0	561,652	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.558186	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.037560	0	67,486	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.116752	0	1,823,132	0	0
60.00 06000 LABORATORY	0.276022	0	370,175	0	0
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.423313	0	72,254	0	0
66.00 06600 PHYSICAL THERAPY	0.626843	0	128,059	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.344882	0	35,867	0	0
68.00 06800 SPEECH PATHOLOGY	1.400282	0	2,392	0	0
69.00 06900 ELECTROCARDIOLOGY	0.025384	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.272376	0	81,310	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.318125	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.363654	0	223,796	0	0
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	1.620491	0	0	0	0
90.01 09001 LI FEBRI DGE SENIOR CARE	2.320780	0	0	0	0
91.00 09100 EMERGENCY	0.330165	0	1,550,205	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.020316	0	56,022	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	0.691436	0	0	0	95.00
200.00 Subtotal (see instructions)		0	4,972,350	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	4,972,350	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/21/2015 9:27 am
	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		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	123,448	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	2,535	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	212,854	0		54.00
60.00 06000 LABORATORY	102,176	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	30,586	0		65.00
66.00 06600 PHYSICAL THERAPY	80,273	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	12,370	0		67.00
68.00 06800 SPEECH PATHOLOGY	3,349	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	22,147	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	81,384	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 LI THOTRI PSY	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 LI FEBRI DGE SENIOR CARE	0	0		90.01
91.00 09100 EMERGENCY	511,823	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	57,160	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	1,240,105	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	1,240,105	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/21/2015 9:27 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,747	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,191	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)		2,528	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		401	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		155	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,015	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)		401	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,500,719	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)		19,115	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)		519,427	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,981,292	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,981,292	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,247.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,266,375	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)		1,266,375	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/21/2015 9:27 am
Title XVIII			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	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)					862,736 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,129,111 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					500,312 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)					500,312 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)					663 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,247.66 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					827,199 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/21/2015 9:27 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	585,841	3,981,292	0.147148	827,199	121,721	90.00
91.00	Nursing School cost	0	3,981,292	0.000000	827,199	0	91.00
92.00	Allied health cost	0	3,981,292	0.000000	827,199	0	92.00
93.00	All other Medical Education	0	3,981,292	0.000000	827,199	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/21/2015 9:27 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,747	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,191	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)		2,528	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		401	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		155	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)		230	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)		593	15.00
16.00	Nursery days (title V or XIX only)		197	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,500,719	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)		502,445	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,998,274	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,998,274	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,252.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		288,185	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)		288,185	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/21/2015 9:27 am		
Cost Center Description			Title XIX	Hospital	PPS		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	338,825	593	571.37	197	112,560	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)					534,785	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					935,530	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)					41,455	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					30,638	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					72,093	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					863,437	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)					663	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,252.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					830,726	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151323

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

Worksheet D-1  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Title XIX Hospital PPS		
				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	585,841	3,998,274	0.146523	830,726	121,720	90.00
91.00 Nursing School cost	0	3,998,274	0.000000	830,726	0	91.00
92.00 Allied health cost	0	3,998,274	0.000000	830,726	0	92.00
93.00 All other Medical Education	0	3,998,274	0.000000	830,726	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/21/2015 9:27 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		1,276,602		30.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.219794	566,762	124,571	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.558186	6,299	3,516	52.00
53.00	05300 ANESTHESIOLOGY	0.037560	71,644	2,691	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116752	347,266	40,544	54.00
60.00	06000 LABORATORY	0.276022	291,209	80,380	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.423313	184,482	78,094	65.00
66.00	06600 PHYSICAL THERAPY	0.626843	91,583	57,408	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.344882	77,096	26,589	67.00
68.00	06800 SPEECH PATHOLOGY	1.400282	11,872	16,624	68.00
69.00	06900 ELECTROCARDIOLOGY	0.025384	53,928	1,369	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.272376	136,285	37,121	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.318125	423,727	134,798	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.363654	684,518	248,928	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 LI THOTRI PSY	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	1.620491	0	0	90.00
90.01	09001 LI FEBRI DGE SENIOR CARE	2.320780	0	0	90.01
91.00	09100 EMERGENCY	0.330165	30,601	10,103	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.020316	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		2,977,272	862,736	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		2,977,272		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3
		Component CCN: 15Z323		Date/Time Prepared: 5/21/2015 9:27 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		211,310		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.219794	163	36	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.558186	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.037560	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116752	12,624	1,474	54.00
60.00	06000 LABORATORY	0.276022	39,772	10,978	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.423313	18,612	7,879	65.00
66.00	06600 PHYSICAL THERAPY	0.626843	88,564	55,516	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.344882	79,216	27,320	67.00
68.00	06800 SPEECH PATHOLOGY	1.400282	5,939	8,316	68.00
69.00	06900 ELECTROCARDIOLOGY	0.025384	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.272376	5,131	1,398	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.318125	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.363654	67,239	24,452	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 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	1.620491	0	0	90.00
90.01	09001 LI FEBRI DGE SENIOR CARE	2.320780	0	0	90.01
91.00	09100 EMERGENCY	0.330165	1,067	352	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.020316	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)		318,327	137,721	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		318,327		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/21/2015 9:27 am
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Cost Center Description		Title XIX Hospital PPS		
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		178,758	30.00
43.00	04300 NURSERY		249,706	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.219794	546,256	120,064 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.558186	404,210	225,624 52.00
53.00	05300 ANESTHESIOLOGY	0.037560	124,122	4,662 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.116752	108,140	12,626 54.00
60.00	06000 LABORATORY	0.276022	111,467	30,767 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.423313	32,123	13,598 65.00
66.00	06600 PHYSICAL THERAPY	0.626843	5,324	3,337 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.344882	2,764	953 67.00
68.00	06800 SPEECH PATHOLOGY	1.400282	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.025384	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.272376	61,941	16,871 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.318125	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.363654	238,962	86,899 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 LI THOTRI PSY	0.000000	0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	1.620491	0	0 90.00
90.01	09001 LI FEBRI DGE SENIOR CARE	2.320780	0	0 90.01
91.00	09100 EMERGENCY	0.330165	58,709	19,384 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.020316	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50-94 and 96-98)		1,694,018	534,785 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		1,694,018	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/21/2015 9:27 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			3,407,907 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,407,907 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			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)			3,441,986 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)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			26,790 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,072,695 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)			1,342,501 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)			1,342,501 30.00
31.00	Primary payer payments			177 31.00
32.00	Subtotal (line 30 minus line 31)			1,342,324 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			324,953 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			246,964 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			213,579 36.00
37.00	Subtotal (see instructions)			1,589,288 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)			1,589,288 40.00
40.01	Sequestration adjustment (see instructions)			31,786 40.01
41.00	Interim payments			1,583,760 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-26,258 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 151323

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,744,118		1,538,260	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/15/2014	25,700	08/15/2014	45,500	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)		25,700		45,500	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,769,818		1,583,760	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		113,803		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		26,258	6.02	
7.00	Total Medicare program liability (see instructions)		1,883,621		1,557,502	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151323  
Component CCN: 15Z323

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/21/2015 9:27 am

Title XVIII Swing Beds - SNF Cost

		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		650,930		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/15/2014	56,300		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		56,300		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		707,230		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		79,131		0	6.02
7.00	Total Medicare program liability (see instructions)		628,099		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151323

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
5/21/2015 9:27 am

		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			933 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			1,015 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			474 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			2,528 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			70,720,592 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			1,274,802 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			199,373 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			159,459 8.00
9.00	Sequestration adjustment amount (see instructions)			3,189 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			156,270 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			156,270 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151323

Period:

Worksheet E-2

Component CCN: 15Z323

From 01/01/2014

Date/Time Prepared:

To 12/31/2014

5/21/2015 9:27 am

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	505,315	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	139,098	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	401	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	644,413	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	644,413	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	644,413	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,496	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	640,917	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50	
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	640,917	0	19.00	
19.01	Sequestration adjustment (see instructions)	12,818	0	19.01	
20.00	Interim payments	707,230	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-79,131	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151323	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/21/2015 9:27 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services			2,129,111 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,129,111 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,150,402 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,150,402 19.00
20.00	Deductibles (exclude professional component)			250,532 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,899,870 22.00
23.00	Coinsurance			299 23.00
24.00	Subtotal (line 22 minus line 23)			1,899,571 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			29,594 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			22,491 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			12,489 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,922,062 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			1,922,062 30.00
30.01	Sequestration adjustment (see instructions)			38,441 30.01
31.00	Interim payments			1,769,818 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)			113,803 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

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

Provider CCN: 151323

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

Worksheet G

Date/Time Prepared:  
5/21/2015 9:27 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,217	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	4,407,620	0	0	0	4.00
5.00	Other receivable	-27,025	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	239,648	0	0	0	7.00
8.00	Prepaid expenses	120,270	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-1,572,216	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,170,514	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	265,000	0	0	0	12.00
13.00	Land improvements	1,972,720	0	0	0	13.00
14.00	Accumulated depreciation	-860,306	0	0	0	14.00
15.00	Buildings	13,245,217	0	0	0	15.00
16.00	Accumulated depreciation	-2,509,832	0	0	0	16.00
17.00	Leasehold improvements	29,098	0	0	0	17.00
18.00	Accumulated depreciation	-24,630	0	0	0	18.00
19.00	Fixed equipment	7,763,398	0	0	0	19.00
20.00	Accumulated depreciation	-3,658,953	0	0	0	20.00
21.00	Automobiles and trucks	42,445	0	0	0	21.00
22.00	Accumulated depreciation	-42,445	0	0	0	22.00
23.00	Major movable equipment	7,068,042	0	0	0	23.00
24.00	Accumulated depreciation	-5,469,660	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	17,820,094	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,012,312	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,012,312	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,002,920	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	483,916	0	0	0	37.00
38.00	Salaries, wages, and fees payable	543,129	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	770,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	474,935	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,271,980	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	86,599	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	26,155,739	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,242,338	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,514,318	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-2,511,398	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-2,511,398	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,002,920	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151323

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

Worksheet G-1

Date/Time Prepared:  
5/21/2015 9:27 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		-2,511,398		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,600,528			2.00
3.00	Total (sum of line 1 and line 2)		89,130		0	3.00
4.00	ADDITIONS (CREDIT ADJUSTMENTS)	-2,600,529		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		-2,600,529		0	10.00
11.00	Subtotal (line 3 plus line 10)		-2,511,399		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-2,511,399		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)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151323

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/21/2015 9:27 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	3,849,275		3,849,275	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	322,480		322,480	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)	4,171,755		4,171,755	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)	4,171,755		4,171,755	17.00
18.00	Ancillary services	12,963,811		12,963,811	18.00
19.00	Outpatient services	0	54,997,975	54,997,975	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	3,417,864	3,417,864	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
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)	17,135,566	58,415,839	75,551,405	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,725,432		29.00
30.00	BAD DEBT	3,699,144			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)		3,699,144		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)		31,424,576		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151323

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

Worksheet G-3

Date/Time Prepared:  
5/21/2015 9:27 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	75,551,405	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,506,712	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,044,693	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,424,576	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,620,117	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	44,229	6.00
7.00	Income from investments	-1,914	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	202,612	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	27	16.00
17.00	Revenue from sale of drugs to other than patients	277,539	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	11,608	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	31,037	22.00
23.00	Governmental appropriations	0	23.00
24.00		0	24.00
24.01	COUNTY GRANT FOR AMB SERVICES	349,000	24.01
24.02	MISCELLANEOUS	66,273	24.02
25.00	Total other income (sum of lines 6-24)	980,411	25.00
26.00	Total (line 5 plus line 25)	2,600,528	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)	2,600,528	29.00