

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: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/29/2015 10:47 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2015	Time: 10:47 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARYS HOSPITAL ( 140034 ) 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	-356,229	176,314	-73,476	0	1.00
2.00 Subprovider - IPF	0	19,725	-56		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
12.20 OUTPATIENT PHYSICAL THERAPY I	0		0		0	12.20
200.00 Total	0	-336,504	176,258	-73,476	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 9:34 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 400 NORTH PLEASANT AVENUE		PO Box:									
2.00	City: CENTRALIA		State: IL		Zip Code: 62801-		County: MARION					
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
		Hospital and Hospital-Based Component Identification:										
3.00	Hospital		ST. MARYS HOSPITAL		140034	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF		ST. MARYS PSYCH		14S034	99914	4	01/01/2002	N	P	P	4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
17.10	Hospital-Based (CORF) I											17.10
17.20	Hospital-Based (OPT) I		ST MARYS WORK SAFETY INSTITUTE		146668	99914		03/08/2000	N	O	N	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)						1		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		Y	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.			3,253	519	0	0	0	124	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 9:34 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.	0	0	0	0	0		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.					1		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.					01/01/2014	12/31/2014	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: 140034

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 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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	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	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		70.00	
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	

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		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)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
		1.00	2.00	3.00	
<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.	Y			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: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 9:34 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	284,117	0	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	
119.00	DO NOT USE THIS LINE			
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	Y
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.		N	
<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	
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.			
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.			
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.			
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.			
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.			
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.			
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.			
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.			
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.			
<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	269020
		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: SSM HEALTH	Contractor's Name: A		Contractor's Number: 05301
142.00	Street: 10101 WOODFIELD LANE	PO Box:		
143.00	City: ST. LOUIS	State: MO		Zip Code: 63132
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?		Y	
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	
				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	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	
		Part A	Part B	Title V
		1.00	2.00	3.00
				Title XIX
				4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)				
155.00	Hospital	N	N	N
156.00	Subprovider - IPF	N	N	N
157.00	Subprovider - IRF	N	N	N
158.00	SUBPROVIDER			
159.00	SNF	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N
161.00	CMHC		N	N
161.10	CORF		N	N
161.20	OUTPATIENT PHYSICAL THERAPY		N	N
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 9:34 am	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N		161.40
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	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	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						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)					0.75	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)	07/01/2014		09/30/2014			170.00
						1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)					N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/29/2015 9:34 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)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/12/2015	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.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140034

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/29/2015 9:34 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<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.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<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.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<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.				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.		Y		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.	BRIAN	SCHMEIDLER		41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3524	BRIAN_SCHMEIDLER@SSMHC.COM		43.00

		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)	04/12/2015	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 - GOVERNEMENT 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: 140034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	83	30,430	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		83	30,430	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		95	34,810	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,380		0	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)		107				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: 140034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,823	2,303	13,555			1.00
2.00	HMO and other (see instructions)	773	519				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	8,823	2,303	13,555			7.00
8.00	INTENSIVE CARE UNIT	1,542	426	2,392			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		524	604			13.00
14.00	Total (see instructions)	10,365	3,253	16,551	0.00	586.32	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	382	1,361	2,103	0.00	17.45	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	603.77	27.00
28.00	Observation Bed Days		647	2,584			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			206			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	124	153			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: 140034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 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	2,510	960	4,050	1.00
2.00 HMO and other (see instructions)				186	18		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	2,510	960	4,050		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	102	333	607		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

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 9:34 am			
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	30,362,148	0	30,362,148	1,255,840.32	24.18	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		195,454	0	195,454	2,086.59	93.67	3.00
4.00	Physician-Part A - Administrative		257,869	0	257,869	1,582.54	162.95	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,104,055	38,559	1,142,614	46,250.12	24.71	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		398,975	0	398,975	6,953.07	57.38	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		176,914	0	176,914	1,074.10	164.71	13.00
14.00	Home office salaries & wage-related costs		5,959,596	0	5,959,596	127,977.19	46.57	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		15,492,712	0	15,492,712			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		587,843	0	587,843			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		104,188	0	104,188			21.00
22.00	Physician Part A - Administrative		71,556	0	71,556			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		20,730	0	20,730			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	147,462	0	147,462	0.00	0.00	26.00
27.00	Administrative & General	5.00	3,905,673	-35,293	3,870,380	0.00	0.00	27.00
28.00	Administrative & General under contract (see inst.)		452,947	0	452,947	4,530.00	99.99	28.00
29.00	Maintenance & Repairs	6.00	743,172	-416,715	326,457	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	416,715	416,715	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	113,280	0	113,280	0.00	0.00	31.00
32.00	Housekeeping	9.00	952,617	0	952,617	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	793,055	-681,939	111,116	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	681,939	681,939	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	549,966	0	549,966	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 9:34 am	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medi cal Records & Medi cal Records Li brary	16.00 638,490	0	638,490	0.00	0.00	41.00
42.00	Soci al Servi ce	17.00 147,484	0	147,484	0.00	0.00	42.00
43.00	Other General Servi ce	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part III Date/Time Prepared: 5/29/2015 9:34 am
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	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	30,619,641	0	30,619,641	1,258,283.73	24.33	1.00
2.00	Excluded area salaries (see instructions)	1,104,055	38,559	1,142,614	46,250.12	24.71	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29,515,586	-38,559	29,477,027	1,212,033.61	24.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,535,485	0	6,535,485	136,004.36	48.05	4.00
5.00	Subtotal wage-related costs (see inst.)	15,564,268	0	15,564,268	0.00	52.80	5.00
6.00	Total (sum of lines 3 thru 5)	51,615,339	-38,559	51,576,780	1,348,037.97	38.26	6.00
7.00	Total overhead cost (see instructions)	8,444,146	-35,293	8,408,853	4,530.00	1,856.26	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2015 9:34 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		232,491	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		2,474,095	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		9,497,599	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		194,704	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		88,652	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		5,363	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		85,090	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		346,225	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		1,961,141	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		34,747	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		261,905	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>		<b>15,182,012</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER		37,909	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140034

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	398,975	0	1.00
2.00	Hospital	398,975	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10	
				Date/Time Prepared: 5/29/2015 9:34 am	
				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.285061	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		17,231,313	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		5,641,652	5.00	
6.00	Medicaid charges		143,896,615	6.00	
7.00	Medicaid cost (line 1 times line 6)		41,019,313	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		18,146,348	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		18,146,348	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,721,255	447,079	4,168,334	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,060,785	127,445	1,188,230	21.00
22.00	Partial payment by patients approved for charity care	13,951	49,152	63,103	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,046,834	78,293	1,125,127	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		5,781,300	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		491,530	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		5,289,770	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,507,907	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,633,034	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		20,779,382	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet A			
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	CAP REL COSTS-BLDG & FIXT		1,527,240		1,527,240	350,241	1,877,481	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,085,720		2,085,720	51,758	2,137,478	2.00
3.00	00300	OTHER CAP REL COSTS		0		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	147,462	13,768,369	13,915,831	0	0	13,915,831	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,905,673	17,217,809	21,123,482	-358,528	20,764,954	20,764,954	5.00
6.00	00600	MAINTENANCE & REPAIRS	743,172	1,876,853	2,620,025	-1,786,756	833,269	833,269	6.00
6.01	00601	BIOMEDICAL SERVICES	0	952,992	952,992	0	952,992	952,992	6.01
7.00	00700	OPERATION OF PLANT	0	0	0	1,959,797	1,959,797	1,959,797	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	113,280	386,333	499,613	-114	499,499	499,499	8.00
9.00	00900	HOUSEKEEPING	952,617	250,560	1,203,177	-98,561	1,104,616	1,104,616	9.00
10.00	01000	DIETARY	793,055	646,217	1,439,272	-1,327,978	111,294	111,294	10.00
11.00	01100	CAFETERIA	0	0	0	1,327,978	1,327,978	1,327,978	11.00
13.00	01300	NURSING ADMINISTRATION	549,966	14,879	564,845	0	564,845	564,845	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	638,490	331,375	969,865	0	969,865	969,865	16.00
17.00	01700	SOCIAL SERVICE	147,484	20,784	168,268	-1,258	167,010	167,010	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	195,455	0	195,455	0	195,455	195,455	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	6,056,315	618,560	6,674,875	-576,617	6,098,258	6,098,258	30.00
31.00	03100	INTENSIVE CARE UNIT	1,859,301	699,477	2,558,778	2,696	2,561,474	2,561,474	31.00
40.00	04000	SUBPROVIDER - I/PF	820,216	34,618	854,834	-162	854,672	854,672	40.00
43.00	04300	NURSERY	0	0	0	399,771	399,771	399,771	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	1,651,021	2,190,172	3,841,193	86,617	3,927,810	3,927,810	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	316,975	316,975	316,975	52.00
53.00	05300	ANESTHESIOLOGY	0	1,461,221	1,461,221	0	1,461,221	1,461,221	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,525,665	948,217	2,473,882	1,859	2,475,741	2,475,741	54.00
54.01	05401	CARDIAC REHABILITATION	96,114	1,945	98,059	0	98,059	98,059	54.01
56.01	03470	NUCLEAR MEDICINE	151,169	503,997	655,166	0	655,166	655,166	56.01
57.00	05700	CT SCAN	264,598	88,200	352,798	1,125	353,923	353,923	57.00
58.00	05800	MRI	111,257	39,325	150,582	-7	150,575	150,575	58.00
59.00	05900	CARDIAC CATHETERIZATION	223,493	292,588	516,081	67,816	583,897	583,897	59.00
60.00	06000	LABORATORY	1,399,998	2,422,721	3,822,719	0	3,822,719	3,822,719	60.00
64.00	06400	INTRAVENOUS THERAPY	263,959	48,811	312,770	52,051	364,821	364,821	64.00
65.00	06500	RESPIRATORY THERAPY	652,735	134,936	787,671	20,746	808,417	808,417	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	0	59,718	59,718	59,718	65.98
66.00	06600	PHYSICAL THERAPY	1,404,443	295,037	1,699,480	-31,959	1,667,521	1,667,521	66.00
68.00	06800	SPEECH PATHOLOGY	114,582	3,316	117,898	1,256	119,154	119,154	68.00
69.00	06900	ELECTROCARDIOLOGY	725,037	360,760	1,085,797	0	1,085,797	1,085,797	69.00
70.01	07001	NEUROLOGY	299,273	301,483	600,756	2	600,758	600,758	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	164,327	235,433	399,760	-399,760	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,161,656	3,780,154	4,941,810	0	4,941,810	4,941,810	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	282,604	97,424	380,028	-59,718	320,310	320,310	90.00
90.01	09002	DIABETES EDUCATION	21,685	269	21,954	0	21,954	21,954	90.01
90.02	09001	PSYCH SERVICES	275,626	10,606	286,232	-905	285,327	285,327	90.02
90.04	09003	ANTI COAGULATION CLINIC	110,415	306	110,721	0	110,721	110,721	90.04
91.00	09100	EMERGENCY	2,256,166	1,333,710	3,589,876	27,670	3,617,546	3,617,546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)							92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
99.10	09910	CORF	0	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>									
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,078,309	54,982,417	85,060,726	85,753	85,146,479	85,146,479	118.00
<b>NONREIMBURSABLE COST CENTERS</b>									
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	0	190.00
193.05	19305	OTHER NON-REIMBURSABLE	283,839	551,725	835,564	-162,303	673,261	673,261	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	0	0	0	76,550	76,550	76,550	193.07
193.08	19308	FOUNDATION	0	0	0	0	0	0	193.08
194.00	07951	AHEC	0	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	30,362,148	55,534,142	85,896,290	0	85,896,290	85,896,290	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140034

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

Worksheet A  
Date/Time Prepared:  
5/29/2015 9:34 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	385,301	2,262,782	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	671,655	2,809,133	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,930,150	10,985,681	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,987,186	13,777,768	5.00
6.00	00600	MAINTENANCE & REPAIRS	-669	832,600	6.00
6.01	00601	BIOMEDICAL SERVICES	-442,000	510,992	6.01
7.00	00700	OPERATION OF PLANT	0	1,959,797	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	499,499	8.00
9.00	00900	HOUSEKEEPING	-160	1,104,456	9.00
10.00	01000	DIETARY	-144	111,150	10.00
11.00	01100	CAFETERIA	-320,547	1,007,431	11.00
13.00	01300	NURSING ADMINISTRATION	-848	563,997	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-69,258	900,607	16.00
17.00	01700	SOCIAL SERVICE	-269	166,741	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-195,455	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-15,001	6,083,257	30.00
31.00	03100	INTENSIVE CARE UNIT	-73	2,561,401	31.00
40.00	04000	SUBPROVIDER - IPF	-6,111	848,561	40.00
43.00	04300	NURSERY	0	399,771	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-56,365	3,871,445	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	316,975	52.00
53.00	05300	ANESTHESIOLOGY	-1,299,545	161,676	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-959,636	1,516,105	54.00
54.01	05401	CARDIAC REHABILITATION	-24,123	73,936	54.01
56.01	03470	NUCLEAR MEDICINE	-28,591	626,575	56.01
57.00	05700	CT SCAN	0	353,923	57.00
58.00	05800	MRI	0	150,575	58.00
59.00	05900	CARDIAC CATHETERIZATION	-11,856	572,041	59.00
60.00	06000	LABORATORY	-408,768	3,413,951	60.00
64.00	06400	INTRAVENOUS THERAPY	0	364,821	64.00
65.00	06500	RESPIRATORY THERAPY	-32,246	776,171	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	0	59,718	65.98
66.00	06600	PHYSICAL THERAPY	-123,629	1,543,892	66.00
68.00	06800	SPEECH PATHOLOGY	-10	119,144	68.00
69.00	06900	ELECTROCARDIOLOGY	-359,842	725,955	69.00
70.01	07001	NEUROLOGY	-270,080	330,678	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-37,862	-37,862	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,071	4,942,881	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	320,310	90.00
90.01	09002	DIABETES EDUCATION	0	21,954	90.01
90.02	09001	PSYCH SERVICES	0	285,327	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	110,721	90.04
91.00	09100	EMERGENCY	-1,025,195	2,592,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
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>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,547,592	70,598,887	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	190.00
193.05	19305	OTHER NON-REIMBURSABLE	45,516	718,777	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	193.06
193.07	19307	OUTSIDE PRINTING	0	76,550	193.07
193.08	19308	FOUNDATION	187,448	187,448	193.08
194.00	07951	AHEC	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-14,314,628	71,581,662	200.00

RECLASSIFICATIONS

Provider CCN: 140034

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

Worksheet A-6  
Date/Time Prepared:  
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		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>A - RECLASS FROM OB TO NURSERY</b>						
1.00	NURSERY	43.00	350,419	49,352	1.00	
	O		350,419	49,352		
<b>B - RECLASS FROM OB TO DELIVERY ROOM</b>						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	272,794	38,420	1.00	
	O		272,794	38,420		
<b>C - RECLASS FROM DIETARY TO CAFETERIA</b>						
1.00	CAFETERIA	11.00	681,939	646,039	1.00	
	O		681,939	646,039		
<b>D - RECLASS IV PUMP COST</b>						
1.00	ADULTS & PEDIATRICS	30.00	0	134,368	1.00	
2.00	INTENSIVE CARE UNIT	31.00	0	2,696	2.00	
3.00	SUBPROVIDER - IPF	40.00	0	8	3.00	
4.00	OPERATING ROOM	50.00	0	46	4.00	
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	5,761	5.00	
6.00	INTRAVENOUS THERAPY	64.00	0	52,051	6.00	
7.00	EMERGENCY	91.00	0	27,670	7.00	
	O		0	222,600		
<b>E - RECLASS MAILROOM COST</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,265	0	1.00	
	O		3,265	0		
<b>F - RECLASS CENTRAL SERVICE COST</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	1	0	1.00	
2.00	OPERATING ROOM	50.00	75,567	11,004	2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	1,623	236	3.00	
4.00	CT SCAN	57.00	982	143	4.00	
5.00	CARDIAC CATHETERIZATION	59.00	59,196	8,620	5.00	
6.00	RESPIRATORY THERAPY	65.00	18,109	2,637	6.00	
7.00	PHYSICAL THERAPY	66.00	4,487	653	7.00	
8.00	SPEECH PATHOLOGY	68.00	1,096	160	8.00	
9.00	NEUROLOGY	70.01	1	1	9.00	
	O		161,062	23,454		
<b>G - RECLASS INTEREST &amp; FINANCIN</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	162,500	1.00	
	O		0	162,500		
<b>H - RECLASS PLANT OPERATIONS</b>						
1.00	OPERATION OF PLANT	7.00	416,715	1,370,041	1.00	
	O		416,715	1,370,041		
<b>I - RECLASS O/S PRINTING TO NON-REIMBURS</b>						
1.00	OUTSIDE PRINTING	193.07	38,559	37,991	1.00	
	O		38,559	37,991		
<b>J - RECLASS INVENTORY COST</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	10,621	1.00	
	O		0	10,621		
<b>K - RECLASS DOCUMENT SHREDDING</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	97,765	1.00	
	O		0	97,765		
<b>L - RECLASS UTILITIES</b>						
1.00	OPERATION OF PLANT	7.00	0	173,041	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	
	O		0	173,041		
<b>M - RECLASS REAL ESTATE TAXES</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	106,838	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	O		0	106,838		
<b>N - RECLASS HYPERBARIC OXYGEN THERAPY</b>						
1.00	HYPERBARIC OXYGEN THERAPY	65.98	50,099	9,619	1.00	
	O		50,099	9,619		
<b>O - BUILDING INSURANCE</b>						
1.00	OTHER CAP REL COSTS	3.00	0	132,661	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	132,661		
500.00	Grand Total: Increases		1,974,852	3,080,942	500.00	

RECLASSIFICATIONS

Provider CCN: 140034

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

Worksheet A-6  
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - RECLASS FROM OB TO NURSERY</b>							
1.00	ADULTS & PEDIATRICS	30.00	350,419	49,352	0		1.00
	O		350,419	49,352			
<b>B - RECLASS FROM OB TO DELIVERY ROOM</b>							
1.00	ADULTS & PEDIATRICS	30.00	272,794	38,420	0		1.00
	O		272,794	38,420			
<b>C - RECLASS FROM DIETARY TO CAFETERIA</b>							
1.00	DIETARY	10.00	681,939	646,039	0		1.00
	O		681,939	646,039			
<b>D - RECLASS IV PUMP COST</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	222,600	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	O		0	222,600			
<b>E - RECLASS MAILROOM COST</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	3,265	0	0		1.00
	O		3,265	0			
<b>F - RECLASS CENTRAL SERVICE COST</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	161,062	23,454	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	O		161,062	23,454			
<b>G - RECLASS INTEREST &amp; FINANCIN</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	162,500	11		1.00
	O		0	162,500			
<b>H - RECLASS PLANT OPERATIONS</b>							
1.00	MAINTENANCE & REPAIRS	6.00	416,715	1,370,041	0		1.00
	O		416,715	1,370,041			
<b>I - RECLASS O/S PRINTING TO NON-REIMBURS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	38,559	37,991	0		1.00
	O		38,559	37,991			
<b>J - RECLASS INVENTORY COST</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,621	0		1.00
	O		0	10,621			
<b>K - RECLASS DOCUMENT SHREDDING</b>							
1.00	HOUSEKEEPING	9.00	0	97,765	0		1.00
	O		0	97,765			
<b>L - RECLASS UTILITIES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	74,765	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	114	0		2.00
3.00	HOUSEKEEPING	9.00	0	796	0		3.00
4.00	SOCIAL SERVICE	17.00	0	1,258	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	170	0		5.00
6.00	MRI	58.00	0	7	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	22,599	0		7.00
8.00	PSYCH SERVICES	90.02	0	905	0		8.00
9.00	OTHER NON-REIMBURSABLE	193.05	0	72,427	0		9.00
	O		0	173,041			
<b>M - RECLASS REAL ESTATE TAXES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,962	13		1.00
2.00	PHYSICAL THERAPY	66.00	0	13,000	0		2.00
3.00	OTHER NON-REIMBURSABLE	193.05	0	89,876	0		3.00
	O		0	106,838			
<b>N - RECLASS HYPERBARI C OXYGEN THERAPY</b>							
1.00	CLINIC	90.00	50,099	9,619	0		1.00
	O		50,099	9,619			
<b>O - BUI LDING INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	131,161	12		1.00
2.00	PHYSICAL THERAPY	66.00	0	1,500	0		2.00
	TOTALS		0	132,661			
500.00	Grand Total: Decreases		1,974,852	3,080,942			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140034

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	1,259,000	0	0	0	1.00
2.00	Land Improvements	667,527	0	0	0	2.00
3.00	Buildings and Fixtures	28,393,459	2,594,398	0	2,594,398	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	1,709,304	340,236	0	340,236	5.00
6.00	Movable Equipment	17,385,608	2,100,260	0	2,100,260	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	49,414,898	5,034,894	0	5,034,894	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	49,414,898	5,034,894	0	5,034,894	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	1,259,000	0			1.00
2.00	Land Improvements	667,527	0			2.00
3.00	Buildings and Fixtures	27,819,835	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	2,049,540	0			5.00
6.00	Movable Equipment	18,994,126	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	50,790,028	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	50,790,028	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140034

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,527,240	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,085,720	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,612,960	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,527,240				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,085,720				2.00
3.00	Total (sum of lines 1-2)	0	3,612,960				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140034

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/29/2015 9:34 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	29,689,375	0	29,689,375	0.609845	80,903	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,994,126	0	18,994,126	0.390155	51,758	2.00
3.00	Total (sum of lines 1-2)	48,683,501	0	48,683,501	1.000000	132,661	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	80,903	1,912,541	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	51,758	2,757,375	0	2.00
3.00	Total (sum of lines 1-2)	0	0	132,661	4,669,916	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	162,500	80,903	106,838	0	2,262,782	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	51,758	0	0	2,809,133	2.00
3.00	Total (sum of lines 1-2)	162,500	132,661	106,838	0	5,071,915	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
1.00	2.00	3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-8,272		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	12,757		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-4,445,802				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-70		RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-9,122,104				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-311,349		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	A	-7,119		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	417,291		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	79,535		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist	A	-195,455		NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
34.00 MI SC. REVENUE	B	-32,311	ADMINISTRATIVE & GENERAL		5.00	0 34.00
35.00 MI SC. REVENUE	A	1,071	DRUGS CHARGED TO PATIENTS		73.00	0 35.00
35.02 MI SC. REVENUE	B	-160	HOUSEKEEPING		9.00	0 35.02
37.00 CARDIOLOGY	A	-4,150	ELECTROCARDIOLOGY		69.00	0 37.00
38.00 BABY PHOTO INCOME	B	-174	ADULTS & PEDIATRICS		30.00	0 38.00
39.00 MANAGEMENT FEES	B	-144,500	RADIOLOGY-DIAGNOSTIC		54.00	0 39.00
40.00 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-6	OPERATING ROOM		50.00	0 40.00
41.01 CLASS FEES	B	-3,312	RESPIRATORY THERAPY		65.00	0 41.01
42.00 MEDICAL RECORDS & MI SC. INCOME	B	-25,401	PHYSICAL THERAPY		66.00	0 42.00
44.00 MI SC. REVENUE	B	-9,198	CAFETERIA		11.00	0 44.00
44.01 MI SC. REVENUE	B	-602	MAINTENANCE & REPAIRS		6.00	0 44.01
44.02 MI SC. REVENUE	B	-5,700	OPERATING ROOM		50.00	0 44.02
44.03 MI SC. REVENUE	B	-13,488	CARDIAC REHABILITATION		54.01	0 44.03
45.00 MI SC. REVENUE	B	-62,119	MEDICAL RECORDS & LIBRARY		16.00	0 45.00
45.01 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-24,684	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.01
45.02 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-68,214	ADMINISTRATIVE & GENERAL		5.00	0 45.02
45.03 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-67	MAINTENANCE & REPAIRS		6.00	0 45.03
45.04		0			0.00	0 45.04
45.05 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-144	DIETARY		10.00	0 45.05
45.06 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-848	NURSING ADMINISTRATIVE		13.00	0 45.06
45.07 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-20	MEDICAL RECORDS & LIBRARY		16.00	0 45.07
45.08 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-269	SOCIAL SERVICE		17.00	0 45.08
45.09 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-3,465	ADULTS & PEDIATRICS		30.00	0 45.09
45.10 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-73	INTENSIVE CARE UNIT		31.00	0 45.10
45.11 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-130	SUBPROVIDER - IPF		40.00	0 45.11
45.12 AMORTIZATION OF GOODWILL	A	-140,151	CAP REL COSTS-MVBLE EQUIP		2.00	9 45.12
45.13 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-202	PHYSICAL THERAPY		66.00	0 45.13
45.14 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-840	FOUNDATION		193.08	0 45.14
45.15 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-79	LABORATORY		60.00	0 45.15
45.16 PATIENT TELEPHONE SERVICE	A	-15,736	ADMINISTRATIVE & GENERAL		5.00	0 45.16
45.17 PATIENT TELEPHONE SERVICE	A	-25	CAP REL COSTS-BLDG & FIXT		1.00	9 45.17
45.18 PERSONAL USE (AUTO)	A	-1,315	CAP REL COSTS-MVBLE EQUIP		2.00	9 45.18
45.21 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-398	EMERGENCY		91.00	0 45.21
45.25 PHYSICIAN RECRUITMENT	A	-151,300	ADMINISTRATIVE & GENERAL		5.00	0 45.25
45.26		0			0.00	0 45.26
45.27		0			0.00	0 45.27
45.28		0			0.00	0 45.28
45.29 PATIENT TELEPHONE SERVICE	A	-524	CAP REL COSTS-MVBLE EQUIP		2.00	9 45.29
45.30 PATIENT TELEPHONE SERVICE BENEF	A	-5,847	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.30
45.31 MEDICAL RECORDS BENEFITS	A	-2,100	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.31
45.32 PROF LAB INS DEDUCTIBLE RESERV	A	88,000	ADMINISTRATIVE & GENERAL		5.00	0 45.32
45.35 CANCER CENTER OFFSETS	A	-3,988	OTHER NON-REIMBURSABLE		193.05	0 45.35
45.36 FOUNDATION EXPENSE OFFSETS	A	71,037	FOUNDATION		193.08	0 45.36
45.37 FOUNDATION SALARY OFFSETS	A	117,251	FOUNDATION		193.08	0 45.37
45.38 CRNA FEES	A	-3,249	ANESTHESIOLOGY		53.00	0 45.38
45.39 CRNA BENEFITS	A	-89,582	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.39
45.40 WSI RENT EXPENSE	A	-49,504	PHYSICAL THERAPY		66.00	0 45.40
45.41 WIS RENT EXPENSE	A	49,504	OTHER NON-REIMBURSABLE		193.05	0 45.41
45.43 INTEREST EXP. UNNECESSARY BORRO	A	-162,500	CAP REL COSTS-BLDG & FIXT		1.00	9 45.43
45.46 DUES RELATED TO LOBBYING EXP.	A	-34,417	ADMINISTRATIVE & GENERAL		5.00	0 45.46
46.00 GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-10	SPEECH PATHOLOGY		68.00	0 46.00

Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8 Date/Time Prepared: 5/29/2015 9:34 am
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
47.00 GIFTS CONTRIBUTIONS & ENTERTAI	A	-101	NEUROLOGY	70.01	0	47.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,314,628				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: 140034

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

Worksheet A-8-1

Date/Time Prepared: 5/29/2015 9:34 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	130,535	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	734,110	0
3.00	0.00		HOME OFFICE - INTEREST	0	0
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	9,092,839	11,900,776
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	7,147,652	13,846,602
4.02	6.01	BIOMEDICAL SERVICES	HOME OFFICE	0	442,000
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-37,862	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,067,274	26,189,378

\* 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>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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	0.00	MOTHERHOUSE	0.00	6.00
7.00	B	0.00	SSM	0.00	7.00
8.00	B	0.00	FSI	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: 140034

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

Worksheet A-8-1

Date/Time Prepared:  
5/29/2015 9:34 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	130,535	9		1.00
2.00	734,110	9		2.00
3.00	0	0		3.00
4.00	-2,807,937	0		4.00
4.01	-6,698,950	0		4.01
4.02	-442,000	0		4.02
4.03	-37,862	0		4.03
5.00	-9,122,104			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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	CONVENT		6.00
7.00	CORPORATE		7.00
8.00	CORPORATE		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: 140034

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2015 9:34 am

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	182,997	175	182,822	159,800	1,357	1.00
2.00	30.00	11,362	11,362	0	130,900	0	2.00
3.00	40.00	14,783	0	14,783	138,700	132	3.00
4.00	50.00	70,268	22,993	47,275	182,900	223	4.00
5.00	53.00	1,320,938	1,265,888	55,050	167,500	306	5.00
6.00	54.00	820,820	807,070	13,750	217,600	55	6.00
7.00	54.01	16,243	0	16,243	159,800	73	7.00
8.00	56.01	28,591	28,591	0	217,600	0	8.00
9.00	59.00	17,080	0	17,080	159,800	68	9.00
10.00	60.00	429,889	389,169	40,720	208,000	212	10.00
11.00	65.00	41,303	20,256	21,047	159,800	161	11.00
12.00	66.00	54,480	48,522	5,958	159,800	79	12.00
13.00	69.00	362,222	341,486	20,736	159,800	85	13.00
14.00	70.01	279,045	258,985	20,060	159,800	118	14.00
15.00	91.00	1,024,797	1,024,797	0	159,800	0	15.00
200.00		4,674,818	4,219,294	455,524		2,869	200.00
Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	104,254	5,213	0	0	0	1.00
2.00	30.00	0	0	0	0	0	2.00
3.00	40.00	8,802	440	0	0	0	3.00
4.00	50.00	19,609	980	0	0	0	4.00
5.00	53.00	24,642	1,232	0	0	0	5.00
6.00	54.00	5,754	288	0	0	0	6.00
7.00	54.01	5,608	280	0	0	0	7.00
8.00	56.01	0	0	0	0	0	8.00
9.00	59.00	5,224	261	0	0	0	9.00
10.00	60.00	21,200	1,060	0	0	0	10.00
11.00	65.00	12,369	618	0	0	0	11.00
12.00	66.00	6,069	303	0	0	0	12.00
13.00	69.00	6,530	327	0	0	0	13.00
14.00	70.01	9,066	453	0	0	0	14.00
15.00	91.00	0	0	0	0	0	15.00
200.00		229,127	11,455	0	0	0	200.00
Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	0	104,254	78,568	78,743		1.00
2.00	30.00	0	0	0	11,362		2.00
3.00	40.00	0	8,802	5,981	5,981		3.00
4.00	50.00	0	19,609	27,666	50,659		4.00
5.00	53.00	0	24,642	30,408	1,296,296		5.00
6.00	54.00	0	5,754	7,996	815,066		6.00
7.00	54.01	0	5,608	10,635	10,635		7.00
8.00	56.01	0	0	0	28,591		8.00
9.00	59.00	0	5,224	11,856	11,856		9.00
10.00	60.00	0	21,200	19,520	408,689		10.00
11.00	65.00	0	12,369	8,678	28,934		11.00
12.00	66.00	0	6,069	0	48,522		12.00
13.00	69.00	0	6,530	14,206	355,692		13.00
14.00	70.01	0	9,066	10,994	269,979		14.00
15.00	91.00	0	0	0	1,024,797		15.00
200.00		0	229,127	226,508	4,445,802		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140034

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,262,782	2,262,782			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,809,133		2,809,133		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,985,681	12,073	0	10,997,754	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,777,768	696,098	442,686	1,411,963	16,328,515
6.00 00600	MAINTENANCE & REPAIRS	832,600	45,227	0	119,489	997,316
6.01 00601	BIOMEDICAL SERVICES	510,992	5,570	0	0	516,562
7.00 00700	OPERATION OF PLANT	1,959,797	116,409	106,755	152,526	2,335,487
8.00 00800	LAUNDRY & LINEN SERVICE	499,499	39,379	1,728	41,463	582,069
9.00 00900	HOUSEKEEPING	1,104,456	28,750	9,749	348,676	1,491,631
10.00 01000	DIETARY	111,150	15,847	5,183	108,512	240,692
11.00 01100	CAFETERIA	1,007,431	42,463	13,889	181,761	1,245,544
13.00 01300	NURSING ADMINISTRATION	848,997	4,126	227,524	201,298	996,945
16.00 01600	MEDICAL RECORDS & LIBRARY	900,607	33,247	2,766	232,023	1,168,643
17.00 01700	SOCIAL SERVICE	166,741	4,229	0	53,982	224,952
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,083,257	287,672	161,204	1,984,474	8,516,607
31.00 03100	INTENSIVE CARE UNIT	2,561,401	29,905	203,213	680,539	3,475,058
40.00 04000	SUBPROVIDER - IPF	848,561	36,945	0	300,215	1,185,721
43.00 04300	NURSERY	399,771	20,716	22,633	128,260	571,380
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	3,871,445	253,646	511,554	631,964	5,268,609
52.00 05200	DELIVERY ROOM & LABOR ROOM	316,975	34,593	17,620	99,848	469,036
53.00 05300	ANESTHESIOLOGY	161,676	2,145	24,562	0	188,383
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,516,105	69,552	493,523	559,016	2,638,196
54.01 05401	CARDIAC REHABILITATION	73,936	0	7,009	35,180	116,125
56.01 03470	NUCLEAR MEDICINE	626,575	4,868	24,294	55,331	711,068
57.00 05700	CT SCAN	353,923	3,847	112,862	97,207	567,839
58.00 05800	MRI	150,575	2,104	5,075	40,722	198,476
59.00 05900	CARDIAC CATHETERIZATION	572,041	27,291	7,122	103,470	709,924
60.00 06000	LABORATORY	3,413,951	37,496	108,375	512,426	4,072,248
64.00 06400	INTRAVENOUS THERAPY	364,821	5,472	2,516	96,614	469,423
65.00 06500	RESPIRATORY THERAPY	776,171	9,690	44,062	245,542	1,075,465
65.98 06501	HYPERBARIC OXYGEN THERAPY	59,718	1,067	15,050	3,521	79,356
66.00 06600	PHYSICAL THERAPY	1,543,892	25,620	16,532	515,695	2,101,739
68.00 06800	SPEECH PATHOLOGY	119,144	3,992	3,587	42,340	169,063
69.00 06900	ELECTROCARDIOLOGY	725,955	30,937	85,602	253,395	1,095,889
70.01 07001	NEUROLOGY	330,678	11,371	26,067	106,517	474,633
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	-37,862	0	0	0	-37,862
73.00 07300	DRUGS CHARGED TO PATIENTS	4,942,881	14,893	23,980	425,188	5,406,942
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	320,310	1,573	15,050	99,918	436,851
90.01 09002	DIABETES EDUCATION	21,954	330	0	7,937	30,221
90.02 09001	PSYCH SERVICES	285,327	54,040	792	100,884	441,043
90.04 09003	ANTI COAGULATION CLINIC	110,721	516	0	40,414	151,651
91.00 09100	EMERGENCY	2,592,351	30,674	44,472	818,525	3,486,022
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	70,598,887	2,044,373	2,787,036	10,836,835	70,197,462
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	1,691	0	0	1,691
193.05 19305	OTHER NON-REIMBURSABLE	718,777	215,975	9,355	103,890	1,047,997
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	0
193.07 19307	OUTSIDE PRINTING	76,550	0	12,742	14,113	103,405
193.08 19308	FOUNDATION	187,448	743	0	42,916	231,107
194.00 07951	AHEC	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	71,581,662	2,262,782	2,809,133	10,997,754	71,581,662

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140034

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	BIOMEDICAL SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.00	6.00	6.01	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,328,515					5.00
6.00	00600	MAINTENANCE & REPAIRS	294,527	1,291,843				6.00
6.01	00601	BIOMEDICAL SERVICES	152,551	570	669,683			6.01
7.00	00700	OPERATION OF PLANT	689,716	794,542	0	3,819,745		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	171,897	29,081	0	108,416	891,463	8.00
9.00	00900	HOUSEKEEPING	440,508	10,834	0	79,154	44,506	9.00
10.00	01000	DIETARY	71,081	13,033	0	43,630	3,294	10.00
11.00	01100	CAFETERIA	367,834	34,864	0	116,906	8,822	11.00
13.00	01300	NURSING ADMINISTRATION	294,418	3,177	27,331	11,358	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	345,124	4,154	0	91,535	0	16.00
17.00	01700	SOCIAL SERVICE	66,433	1,385	0	11,642	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,515,097	87,730	49,752	792,007	300,820	30.00
31.00	03100	INTENSIVE CARE UNIT	1,026,254	17,839	15,547	82,334	68,582	31.00
40.00	04000	SUBPROVIDER - IPF	350,167	6,517	655	101,714	18,747	40.00
43.00	04300	NURSERY	168,740	6,761	7,365	57,033	4,116	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,555,926	56,939	176,420	698,329	130,949	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	138,516	5,376	5,728	95,240	32,915	52.00
53.00	05300	ANESTHESIOLOGY	55,633	0	27,003	5,906	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	779,112	40,729	92,139	191,488	69,552	54.00
54.01	05401	CARDIAC REHABILITATION	34,294	1,303	655	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	209,993	2,932	3,273	13,403	0	56.01
57.00	05700	CT SCAN	167,694	326	26,185	10,592	0	57.00
58.00	05800	MRI	58,614	2,607	11,947	5,793	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	209,655	3,829	43,860	75,136	5,292	59.00
60.00	06000	LABORATORY	1,202,616	23,134	17,348	103,234	201	60.00
64.00	06400	INTRAVENOUS THERAPY	138,630	1,874	0	15,064	3,787	64.00
65.00	06500	RESPIRATORY THERAPY	317,606	1,466	41,569	26,678	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	23,435	0	0	2,939	0	65.98
66.00	06600	PHYSICAL THERAPY	620,686	10,182	12,111	70,536	44,167	66.00
68.00	06800	SPEECH PATHOLOGY	49,928	81	1,800	10,989	0	68.00
69.00	06900	ELECTROCARDIOLOGY	323,638	8,146	27,658	85,174	10,823	69.00
70.01	07001	NEUROLOGY	140,169	1,222	66,281	31,307	7,455	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,596,778	4,806	0	41,004	837	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	129,011	18,654	0	4,330	5,000	90.00
90.01	09002	DIABETES EDUCATION	8,925	0	0	909	0	90.01
90.02	09001	PSYCH SERVICES	130,249	14,337	327	148,781	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	44,786	0	0	1,420	122,022	90.04
91.00	09100	EMERGENCY	1,029,492	17,432	13,256	84,450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,919,733	1,225,862	668,210	3,218,431	881,887	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	499	0	0	4,657	0	190.00
193.05	19305	OTHER NON-REIMBURSABLE	309,494	64,678	1,473	594,612	9,576	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	30,538	1,303	0	0	0	193.07
193.08	19308	FOUNDATION	68,251	0	0	2,045	0	193.08
194.00	07951	AHEC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,328,515	1,291,843	669,683	3,819,745	891,463	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part I Date/Time Prepared: 5/29/2015 9:34 am	
Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	BIOMEDICAL SERVICES						6.01
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,066,633					9.00
10.00	01000	DIETARY	781	372,511				10.00
11.00	01100	CAFETERIA	1,954	0	1,775,924			11.00
13.00	01300	NURSING ADMINISTRATION	1,172	0	30,686	1,365,087		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,319	0	69,042	54,003	1,752,820	16.00
17.00	01700	SOCIAL SERVICE	3,126	0	11,507	9,001	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	593,928	270,777	460,285	360,024	516,510	30.00
31.00	03100	INTENSIVE CARE UNIT	94,950	27,283	122,742	96,006	94,599	31.00
40.00	04000	SUBPROVIDER - IPF	149,654	37,054	65,207	51,003	75,926	40.00
43.00	04300	NURSERY	22,272	0	23,014	18,001	24,134	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	218,034	6,917	130,413	102,007	120,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,100	0	15,343	12,001	16,912	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	14,974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,426	6,313	103,564	81,005	94,952	54.00
54.01	05401	CARDIAC REHABILITATION	25,789	0	7,671	6,000	1,762	54.01
56.01	03470	NUCLEAR MEDICINE	5,470	0	7,671	6,000	26,424	56.01
57.00	05700	CT SCAN	10,159	0	19,178	15,001	142,692	57.00
58.00	05800	MRI	10,550	0	7,671	6,000	30,652	58.00
59.00	05900	CARDIAC CATHETERIZATION	33,995	1,115	19,178	15,001	16,559	59.00
60.00	06000	LABORATORY	43,372	0	134,249	105,007	218,970	60.00
64.00	06400	INTRAVENOUS THERAPY	25,789	1,533	19,178	15,001	8,280	64.00
65.00	06500	RESPIRATORY THERAPY	3,907	0	61,371	48,003	26,601	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	5,080	0	3,836	3,000	2,290	65.98
66.00	06600	PHYSICAL THERAPY	66,426	0	95,892	75,005	27,305	66.00
68.00	06800	SPEECH PATHOLOGY	3,517	0	7,671	6,000	1,585	68.00
69.00	06900	ELECTROCARDIOLOGY	32,432	1,824	53,700	42,003	50,911	69.00
70.01	07001	NEUROLOGY	14,457	963	23,014	18,001	13,917	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,054	0	57,535	45,003	111,687	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	44,935	0	19,178	15,001	6,166	90.00
90.01	09002	DIABETES EDUCATION	0	0	3,836	3,000	0	90.01
90.02	09001	PSYCH SERVICES	84,791	0	23,014	18,001	6,166	90.02
90.04	09003	ANTI COAGULATION CLINIC	2,735	0	3,836	3,000	2,290	90.04
91.00	09100	EMERGENCY	203,186	18,732	153,428	120,008	99,708	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,833,360	372,511	1,752,910	1,347,086	1,752,820	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2,735	0	0	0	0	190.00
193.05	19305	OTHER NON-REIMBURSABLE	230,538	0	19,178	15,001	0	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	0	0	3,836	3,000	0	193.07
193.08	19308	FOUNDATION	0	0	0	0	0	193.08
194.00	07951	AHEC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,066,633	372,511	1,775,924	1,365,087	1,752,820	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140034

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	BIOMEDICAL SERVICES						6.01
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	328,046					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	328,046	0	14,791,583	0	14,791,583	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,121,194	0	5,121,194	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,042,365	0	2,042,365	40.00
43.00	04300	NURSERY	0	0	902,816	0	902,816	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	8,465,391	0	8,465,391	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	812,167	0	812,167	52.00
53.00	05300	ANESTHESIOLOGY	0	0	291,899	0	291,899	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,163,476	0	4,163,476	54.00
54.01	05401	CARDIAC REHABILITATION	0	0	193,599	0	193,599	54.01
56.01	03470	NUCLEAR MEDICINE	0	0	986,234	0	986,234	56.01
57.00	05700	CT SCAN	0	0	959,666	0	959,666	57.00
58.00	05800	MRI	0	0	332,310	0	332,310	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	1,133,544	0	1,133,544	59.00
60.00	06000	LABORATORY	0	0	5,920,379	0	5,920,379	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	698,559	0	698,559	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,602,666	0	1,602,666	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	119,936	0	119,936	65.98
66.00	06600	PHYSICAL THERAPY	0	0	3,124,049	0	3,124,049	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	250,634	0	250,634	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,732,198	0	1,732,198	69.00
70.01	07001	NEUROLOGY	0	0	791,419	0	791,419	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	-37,862	0	-37,862	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	7,287,646	0	7,287,646	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	679,126	0	679,126	90.00
90.01	09002	DIABETES EDUCATION	0	0	46,891	0	46,891	90.01
90.02	09001	PSYCH SERVICES	0	0	866,709	0	866,709	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	0	331,740	0	331,740	90.04
91.00	09100	EMERGENCY	0	0	5,225,714	0	5,225,714	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	328,046	0	68,836,048	0	68,836,048	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	9,582	0	9,582	190.00
193.05	19305	OTHER NON-REIMBURSABLE	0	0	2,292,547	0	2,292,547	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	0	0	142,082	0	142,082	193.07
193.08	19308	FOUNDATION	0	0	301,403	0	301,403	193.08
194.00	07951	AHEC	0	0	0	0	0	194.00
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)	328,046	0	71,581,662	0	71,581,662	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140034

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,073	0	12,073	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,735	696,098	442,686	1,142,519	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	45,227	0	45,227	6.00
6.01 00601	BIOMEDICAL SERVICES	0	5,570	0	5,570	6.01
7.00 00700	OPERATION OF PLANT	0	116,409	106,755	223,164	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	94	39,379	1,728	41,201	8.00
9.00 00900	HOUSEKEEPING	35,759	28,750	9,749	74,258	9.00
10.00 01000	DIETARY	0	15,847	5,183	21,030	10.00
11.00 01100	CAFETERIA	0	42,463	13,889	56,352	11.00
13.00 01300	NURSING ADMINISTRATION	0	4,126	227,524	231,650	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,247	2,766	36,013	16.00
17.00 01700	SOCIAL SERVICE	0	4,229	0	4,229	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	182,797	287,672	161,204	631,673	30.00
31.00 03100	INTENSIVE CARE UNIT	3,788	29,905	203,213	236,906	31.00
40.00 04000	SUBPROVIDER - IPF	8	36,945	0	36,953	40.00
43.00 04300	NURSERY	0	20,716	22,633	43,349	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	54,333	253,646	511,554	819,533	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	5,761	34,593	17,620	57,974	52.00
53.00 05300	ANESTHESIOLOGY	2,665	2,145	24,562	29,372	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,952	69,552	493,523	575,027	54.00
54.01 05401	CARDIAC REHABILITATION	9	0	7,009	7,018	54.01
56.01 03470	NUCLEAR MEDICINE	0	4,868	24,294	29,162	56.01
57.00 05700	CT SCAN	43	3,847	112,862	116,752	57.00
58.00 05800	MRI	9,717	2,104	5,075	16,896	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	27,291	7,122	34,413	59.00
60.00 06000	LABORATORY	93,006	37,496	108,375	238,877	60.00
64.00 06400	INTRAVENOUS THERAPY	52,051	5,472	2,516	60,039	64.00
65.00 06500	RESPIRATORY THERAPY	9,056	9,690	44,062	62,808	65.00
65.98 06501	HYPERBARIC OXYGEN THERAPY	0	1,067	15,050	16,117	65.98
66.00 06600	PHYSICAL THERAPY	74,937	25,620	16,532	117,089	66.00
68.00 06800	SPEECH PATHOLOGY	0	3,992	3,587	7,579	68.00
69.00 06900	ELECTROCARDIOLOGY	178	30,937	85,602	116,717	69.00
70.01 07001	NEUROLOGY	69	11,371	26,067	37,507	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	14,893	23,980	38,873	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	1,573	15,050	16,623	90.00
90.01 09002	DIABETES EDUCATION	0	330	0	330	90.01
90.02 09001	PSYCH SERVICES	126	54,040	792	54,958	90.02
90.04 09003	ANTI COAGULATION CLINIC	0	516	0	516	90.04
91.00 09100	EMERGENCY	27,670	30,674	44,472	102,816	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	567,754	2,044,373	2,787,036	5,399,163	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	1,691	0	1,691	190.00
193.05 19305	OTHER NON-REIMBURSABLE	227,178	215,975	9,355	452,508	193.05
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	193.06
193.07 19307	OUTSIDE PRINTING	0	0	12,742	12,742	193.07
193.08 19308	FOUNDATION	3,796	743	0	4,539	193.08
194.00 07951	AHEC	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	798,728	2,262,782	2,809,133	5,870,643	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/29/2015 9:34 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	BIOMEDICAL SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
		5.00	6.00	6.01	7.00	8.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	1,144,070				5.00	
6.00	00600	MAINTENANCE & REPAIRS	20,636	65,994			6.00	
6.01	00601	BIOMEDICAL SERVICES	10,689	29	16,288		6.01	
7.00	00700	OPERATION OF PLANT	48,326	40,587	0	312,245	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	12,044	1,486	0	8,862	63,639	8.00
9.00	00900	HOUSEKEEPING	30,865	553	0	6,470	3,177	9.00
10.00	01000	DIETARY	4,980	666	0	3,567	235	10.00
11.00	01100	CAFETERIA	25,773	1,781	0	9,557	630	11.00
13.00	01300	NURSING ADMINISTRATION	20,629	162	665	928	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,182	212	0	7,482	0	16.00
17.00	01700	SOCIAL SERVICE	4,655	71	0	952	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	176,214	4,482	1,210	64,743	21,474	30.00
31.00	03100	INTENSIVE CARE UNIT	71,906	911	378	6,730	4,896	31.00
40.00	04000	SUBPROVIDER - IPF	24,535	333	16	8,315	1,338	40.00
43.00	04300	NURSERY	11,823	345	179	4,662	294	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	109,018	2,909	4,289	57,085	9,348	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,705	275	139	7,785	2,350	52.00
53.00	05300	ANESTHESIOLOGY	3,898	0	657	483	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,590	2,081	2,241	15,653	4,965	54.00
54.01	05401	CARDIAC REHABILITATION	2,403	67	16	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	14,713	150	80	1,096	0	56.01
57.00	05700	CT SCAN	11,750	17	637	866	0	57.00
58.00	05800	MRI	4,107	133	291	474	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,690	196	1,067	6,142	378	59.00
60.00	06000	LABORATORY	84,263	1,182	422	8,439	14	60.00
64.00	06400	INTRAVENOUS THERAPY	9,713	96	0	1,231	270	64.00
65.00	06500	RESPIRATORY THERAPY	22,254	75	1,011	2,181	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	1,642	0	0	240	0	65.98
66.00	06600	PHYSICAL THERAPY	43,489	520	295	5,766	3,153	66.00
68.00	06800	SPEECH PATHOLOGY	3,498	4	44	898	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,676	416	673	6,963	773	69.00
70.01	07001	NEUROLOGY	9,821	62	1,612	2,559	532	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	111,880	246	0	3,352	60	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	9,039	953	0	354	357	90.00
90.01	09002	DIABETES EDUCATION	625	0	0	74	0	90.01
90.02	09001	PSYCH SERVICES	9,126	732	8	12,162	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	3,138	0	0	116	8,711	90.04
91.00	09100	EMERGENCY	72,133	891	322	6,903	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,115,428	62,623	16,252	263,090	62,955	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	35	0	0	381	0	190.00
193.05	19305	OTHER NON-REIMBURSABLE	21,685	3,304	36	48,607	684	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	2,140	67	0	0	0	193.07
193.08	19308	FOUNDATION	4,782	0	0	167	0	193.08
194.00	07951	AHEC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,144,070	65,994	16,288	312,245	63,639	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/29/2015 9:34 am	
Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	BIOMEDICAL SERVICES						6.01
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	115,706					9.00
10.00	01000	DIETARY	44	30,641				10.00
11.00	01100	CAFETERIA	109	0	94,402			11.00
13.00	01300	NURSING ADMINISTRATION	66	0	1,631	255,952		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,138	0	3,670	10,126	83,078	16.00
17.00	01700	SOCIAL SERVICE	175	0	612	1,688	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	33,253	22,273	24,470	67,501	24,480	30.00
31.00	03100	INTENSIVE CARE UNIT	5,316	2,244	6,525	18,001	4,484	31.00
40.00	04000	SUBPROVIDER - IPF	8,379	3,048	3,466	9,563	3,599	40.00
43.00	04300	NURSERY	1,247	0	1,223	3,375	1,144	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	12,207	569	6,932	19,126	5,728	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,181	0	816	2,250	802	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	710	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,719	519	5,505	15,188	4,500	54.00
54.01	05401	CARDIAC REHABILITATION	1,444	0	408	1,125	83	54.01
56.01	03470	NUCLEAR MEDICINE	306	0	408	1,125	1,252	56.01
57.00	05700	CT SCAN	569	0	1,019	2,813	6,763	57.00
58.00	05800	MRI	591	0	408	1,125	1,453	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,903	92	1,019	2,813	785	59.00
60.00	06000	LABORATORY	2,428	0	7,136	19,689	10,378	60.00
64.00	06400	INTRAVENOUS THERAPY	1,444	126	1,019	2,813	392	64.00
65.00	06500	RESPIRATORY THERAPY	219	0	3,262	9,001	1,261	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	284	0	204	563	109	65.98
66.00	06600	PHYSICAL THERAPY	3,719	0	5,097	14,063	1,294	66.00
68.00	06800	SPEECH PATHOLOGY	197	0	408	1,125	75	68.00
69.00	06900	ELECTROCARDIOLOGY	1,816	150	2,854	7,875	2,413	69.00
70.01	07001	NEUROLOGY	809	79	1,223	3,375	660	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,291	0	3,058	8,438	5,294	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	2,516	0	1,019	2,813	292	90.00
90.01	09002	DIABETES EDUCATION	0	0	204	563	0	90.01
90.02	09001	PSYCH SERVICES	4,747	0	1,223	3,375	292	90.02
90.04	09003	ANTI COAGULATION CLINIC	153	0	204	563	109	90.04
91.00	09100	EMERGENCY	11,376	1,541	8,156	22,501	4,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	102,646	30,641	93,179	252,576	83,078	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	153	0	0	0	0	190.00
193.05	19305	OTHER NON-REIMBURSABLE	12,907	0	1,019	2,813	0	193.05
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
193.07	19307	OUTSIDE PRINTING	0	0	204	563	0	193.07
193.08	19308	FOUNDATION	0	0	0	0	0	193.08
194.00	07951	AHEC	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	115,706	30,641	94,402	255,952	83,078	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/29/2015 9:34 am	
Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	19.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
6.01 00601	BIOMEDICAL SERVICES					6.01
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	12,441				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	12,441	1,086,384	0	1,086,384	30.00
31.00 03100	INTENSIVE CARE UNIT	0	359,044	0	359,044	31.00
40.00 04000	SUBPROVIDER - I/PF	0	99,875	0	99,875	40.00
43.00 04300	NURSERY	0	67,782	0	67,782	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	1,047,438	0	1,047,438	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	83,387	0	83,387	52.00
53.00 05300	ANESTHESIOLOGY	0	35,120	0	35,120	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	684,602	0	684,602	54.00
54.01 05401	CARDIAC REHABILITATION	0	12,603	0	12,603	54.01
56.01 03470	NUCLEAR MEDICINE	0	48,353	0	48,353	56.01
57.00 05700	CT SCAN	0	141,293	0	141,293	57.00
58.00 05800	MRI	0	25,523	0	25,523	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	63,612	0	63,612	59.00
60.00 06000	LABORATORY	0	373,391	0	373,391	60.00
64.00 06400	INTRAVENOUS THERAPY	0	77,249	0	77,249	64.00
65.00 06500	RESPIRATORY THERAPY	0	102,342	0	102,342	65.00
65.98 06501	HYPERBARIC OXYGEN THERAPY	0	19,163	0	19,163	65.98
66.00 06600	PHYSICAL THERAPY	0	195,051	0	195,051	66.00
68.00 06800	SPEECH PATHOLOGY	0	13,875	0	13,875	68.00
69.00 06900	ELECTROCARDIOLOGY	0	163,604	0	163,604	69.00
70.01 07001	NEUROLOGY	0	58,356	0	58,356	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	172,959	0	172,959	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	34,076	0	34,076	90.00
90.01 09002	DIABETES EDUCATION	0	1,805	0	1,805	90.01
90.02 09001	PSYCH SERVICES	0	86,734	0	86,734	90.02
90.04 09003	ANTI COAGULATION CLINIC	0	13,554	0	13,554	90.04
91.00 09100	EMERGENCY	0	232,264	0	232,264	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,441	0	5,299,439	0	5,299,439
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	2,260	0	2,260	190.00
193.05 19305	OTHER NON-REIMBURSABLE	0	543,677	0	543,677	193.05
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	193.06
193.07 19307	OUTSIDE PRINTING	0	15,732	0	15,732	193.07
193.08 19308	FOUNDATION	0	9,535	0	9,535	193.08
194.00 07951	AHEC	0	0	0	0	194.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	12,441	0	5,870,643	0	5,870,643

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	438,780				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,937,431			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,341	0	30,046,912		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	134,982	305,316	3,857,622	-16,328,515	5.00
6.00 00600	MAINTENANCE & REPAIRS	8,770	0	326,457	0	6.00
6.01 00601	BIOMEDICAL SERVICES	1,080	0	0	0	6.01
7.00 00700	OPERATION OF PLANT	22,573	73,628	416,715	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	7,636	1,192	113,280	0	8.00
9.00 00900	HOUSEKEEPING	5,575	6,724	952,617	0	9.00
10.00 01000	DIETARY	3,073	3,575	296,465	0	10.00
11.00 01100	CAFETERIA	8,234	9,579	496,590	0	11.00
13.00 01300	NURSING ADMINISTRATION	800	156,921	549,966	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,447	1,908	633,909	0	16.00
17.00 01700	SOCIAL SERVICE	820	0	147,484	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	55,783	111,181	5,421,740	0	30.00
31.00 03100	INTENSIVE CARE UNIT	5,799	140,154	1,859,301	0	31.00
40.00 04000	SUBPROVIDER - IPF	7,164	0	820,216	0	40.00
43.00 04300	NURSERY	4,017	15,610	350,419	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	49,185	352,813	1,726,588	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,708	12,152	272,794	0	52.00
53.00 05300	ANESTHESIOLOGY	416	16,940	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,487	340,378	1,527,288	0	54.00
54.01 05401	CARDIAC REHABILITATION	0	4,834	96,114	0	54.01
56.01 03470	NUCLEAR MEDICINE	944	16,755	151,169	0	56.01
57.00 05700	CT SCAN	746	77,840	265,580	0	57.00
58.00 05800	MRI	408	3,500	111,257	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	5,292	4,912	282,689	0	59.00
60.00 06000	LABORATORY	7,271	74,745	1,399,998	0	60.00
64.00 06400	INTRAVENOUS THERAPY	1,061	1,735	263,959	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,879	30,389	670,845	0	65.00
65.98 06501	HYPERBARIC OXYGEN THERAPY	207	10,380	9,619	0	65.98
66.00 06600	PHYSICAL THERAPY	4,968	11,402	1,408,929	0	66.00
68.00 06800	SPEECH PATHOLOGY	774	2,474	115,678	0	68.00
69.00 06900	ELECTROCARDIOLOGY	5,999	59,039	692,301	0	69.00
70.01 07001	NEUROLOGY	2,205	17,978	291,015	0	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	37,862	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,888	16,539	1,161,656	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	305	10,380	272,985	0	90.00
90.01 09002	DIABETES EDUCATION	64	0	21,685	0	90.01
90.02 09001	PSYCH SERVICES	10,479	546	275,626	0	90.02
90.04 09003	ANTI COAGULATION CLINIC	100	0	110,415	0	90.04
91.00 09100	EMERGENCY	5,948	30,672	2,236,292	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	396,428	1,922,191	29,607,263	-16,290,653	53,906,809
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	328	0	0	0	190.00
193.05 19305	OTHER NON-REIMBURSABLE	41,880	6,452	283,839	0	193.05
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	193.06
193.07 19307	OUTSIDE PRINTING	0	8,788	38,559	0	193.07
193.08 19308	FOUNDATION	144	0	117,251	0	193.08
194.00 07951	AHEC	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,262,782	2,809,133	10,997,754		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.156985	1.449927	0.366019		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			12,073		204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
205.00   Unit cost multiplier (Wkst. B, Part II)			0.000402	5A	0.020692	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description		MAINTENANCE & REPAIRS (HOURS OF SERVICE)	BIOMEDICAL SERVICES (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		6.00	6.01	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	15,859					6.00
6.01	00601	7	4,092				6.01
7.00	00700	9,754	0	269,034			7.00
8.00	00800	357	0	7,636	670,164		8.00
9.00	00900	133	0	5,575	33,458	5,289	9.00
10.00	01000	160	0	3,073	2,476	2	10.00
11.00	01100	428	0	8,234	6,632	5	11.00
13.00	01300	39	167	800	0	3	13.00
16.00	01600	51	0	6,447	0	52	16.00
17.00	01700	17	0	820	0	8	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,077	304	55,783	226,145	1,520	30.00
31.00	03100	219	95	5,799	51,557	243	31.00
40.00	04000	80	4	7,164	14,093	383	40.00
43.00	04300	83	45	4,017	3,094	57	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	699	1,078	49,185	98,442	558	50.00
52.00	05200	66	35	6,708	24,744	54	52.00
53.00	05300	0	165	416	0	0	53.00
54.00	05400	500	563	13,487	52,286	170	54.00
54.01	05401	16	4	0	0	66	54.01
56.01	03470	36	20	944	0	14	56.01
57.00	05700	4	160	746	0	26	57.00
58.00	05800	32	73	408	0	27	58.00
59.00	05900	47	268	5,292	3,978	87	59.00
60.00	06000	284	106	7,271	151	111	60.00
64.00	06400	23	0	1,061	2,847	66	64.00
65.00	06500	18	254	1,879	0	10	65.00
65.98	06501	0	0	207	0	13	65.98
66.00	06600	125	74	4,968	33,203	170	66.00
68.00	06800	1	11	774	0	9	68.00
69.00	06900	100	169	5,999	8,136	83	69.00
70.01	07001	15	405	2,205	5,604	37	70.01
71.00	07100	0	0	0	0	0	71.00
73.00	07300	59	0	2,888	629	59	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	229	0	305	3,759	115	90.00
90.01	09002	0	0	64	0	0	90.01
90.02	09001	176	2	10,479	0	217	90.02
90.04	09003	0	0	100	91,731	7	90.04
91.00	09100	214	81	5,948	0	520	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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>							
118.00		15,049	4,083	226,682	662,965	4,692	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	328	0	7	190.00
193.05	19305	794	9	41,880	7,199	590	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	16	0	0	0	0	193.07
193.08	19308	0	0	144	0	0	193.08
194.00	07951	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		1,291,843	669,683	3,819,745	891,463	2,066,633	202.00
203.00		81.458036	163.656647	14.198001	1.330216	390.741728	203.00
204.00		65,994	16,288	312,245	63,639	115,706	204.00
205.00		4.161296	3.980450	1.160615	0.094960	21.876725	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1

Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (FULL TIME EQUIVALENT)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		10.00	11.00	13.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601						6.01
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	88,216					10.00
11.00	01100	0	463				11.00
13.00	01300	0	8	455			13.00
16.00	01600	0	18	18	9,950		16.00
17.00	01700	0	3	3	0	100	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	64,124	120	120	2,932	100	30.00
31.00	03100	6,461	32	32	537	0	31.00
40.00	04000	8,775	17	17	431	0	40.00
43.00	04300	0	6	6	137	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,638	34	34	686	0	50.00
52.00	05200	0	4	4	96	0	52.00
53.00	05300	0	0	0	85	0	53.00
54.00	05400	1,495	27	27	539	0	54.00
54.01	05401	0	2	2	10	0	54.01
56.01	03470	0	2	2	150	0	56.01
57.00	05700	0	5	5	810	0	57.00
58.00	05800	0	2	2	174	0	58.00
59.00	05900	264	5	5	94	0	59.00
60.00	06000	0	35	35	1,243	0	60.00
64.00	06400	363	5	5	47	0	64.00
65.00	06500	0	16	16	151	0	65.00
65.98	06501	0	1	1	13	0	65.98
66.00	06600	0	25	25	155	0	66.00
68.00	06800	0	2	2	9	0	68.00
69.00	06900	432	14	14	289	0	69.00
70.01	07001	228	6	6	79	0	70.01
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	15	15	634	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	5	5	35	0	90.00
90.01	09002	0	1	1	0	0	90.01
90.02	09001	0	6	6	35	0	90.02
90.04	09003	0	1	1	13	0	90.04
91.00	09100	4,436	40	40	566	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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>							
118.00		88,216	457	449	9,950	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
193.05	19305	0	5	5	0	0	193.05
193.06	19306	0	0	0	0	0	193.06
193.07	19307	0	1	1	0	0	193.07
193.08	19308	0	0	0	0	0	193.08
194.00	07951	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		372,511	1,775,924	1,365,087	1,752,820	328,046	202.00
203.00		4,222,715	3,835,688,985	3,000,191,209	176,162,814	3,280,460,000	203.00
204.00		30,641	94,402	255,952	83,078	12,441	204.00
205.00		0.347341	203.892009	562.531868	8.349548	124.410000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140034

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (BLANK)	
		19.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
6.01	00601	BIOMEDICAL SERVICES	6.01
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
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
54.01	05401	CARDIAC REHABILITATION	54.01
56.01	03470	NUCLEAR MEDICINE	56.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	65.98
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.01	07001	NEUROLOGY	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
90.01	09002	DIABETES EDUCATION	90.01
90.02	09001	PSYCH SERVICES	90.02
90.04	09003	ANTI COAGULATION CLINIC	90.04
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
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>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
193.05	19305	OTHER NON-REIMBURSABLE	193.05
193.06	19306	OUTSIDE ACCOUNTING	193.06
193.07	19307	OUTSIDE PRINTING	193.07
193.08	19308	FOUNDATION	193.08
194.00	07951	AHEC	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140034

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	14,791,583	14,791,583	0	14,791,583	30.00
31.00	03100 INTENSIVE CARE UNIT	5,121,194	5,121,194	0	5,121,194	31.00
40.00	04000 SUBPROVIDER - I/PF	2,042,365	2,042,365	5,981	2,048,346	40.00
43.00	04300 NURSERY	902,816	902,816	0	902,816	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	8,465,391	8,465,391	27,666	8,493,057	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	812,167	812,167	0	812,167	52.00
53.00	05300 ANESTHESIOLOGY	291,899	291,899	30,408	322,307	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,163,476	4,163,476	7,996	4,171,472	54.00
54.01	05401 CARDIAC REHABILITATION	193,599	193,599	10,635	204,234	54.01
56.01	03470 NUCLEAR MEDICINE	986,234	986,234	0	986,234	56.01
57.00	05700 CT SCAN	959,666	959,666	0	959,666	57.00
58.00	05800 MRI	332,310	332,310	0	332,310	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,133,544	1,133,544	11,856	1,145,400	59.00
60.00	06000 LABORATORY	5,920,379	5,920,379	19,520	5,939,899	60.00
64.00	06400 INTRAVENOUS THERAPY	698,559	698,559	0	698,559	64.00
65.00	06500 RESPIRATORY THERAPY	1,602,666	1,602,666	8,678	1,611,344	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	119,936	119,936	0	119,936	65.98
66.00	06600 PHYSICAL THERAPY	3,124,049	3,124,049	0	3,124,049	66.00
68.00	06800 SPEECH PATHOLOGY	250,634	250,634	0	250,634	68.00
69.00	06900 ELECTROCARDIOLOGY	1,732,198	1,732,198	14,206	1,746,404	69.00
70.01	07001 NEUROLOGY	791,419	791,419	10,994	802,413	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,287,646	7,287,646	0	7,287,646	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	679,126	679,126	0	679,126	90.00
90.01	09002 DIABETES EDUCATION	46,891	46,891	0	46,891	90.01
90.02	09001 PSYCH SERVICES	866,709	866,709	0	866,709	90.02
90.04	09003 ANTI COAGULATION CLINIC	331,740	331,740	0	331,740	90.04
91.00	09100 EMERGENCY	5,225,714	5,225,714	0	5,225,714	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,368,262	2,368,262	0	2,368,262	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
200.00	Subtotal (see instructions)	71,242,172	71,242,172	147,940	71,390,112	200.00
201.00	Less Observation Beds	2,368,262	2,368,262	0	2,368,262	201.00
202.00	Total (see instructions)	68,873,910	68,873,910	147,940	69,021,850	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 9:34 am
		Title XVIIII	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	13,212,481		13,212,481	30.00
31.00	03100	INTENSIVE CARE UNIT	3,088,631		3,088,631	31.00
40.00	04000	SUBPROVIDER - IPF	1,405,835		1,405,835	40.00
43.00	04300	NURSERY	717,725		717,725	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	8,459,590	16,863,183	25,322,773	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,144,630	1,352,121	3,496,751	52.00
53.00	05300	ANESTHESIOLOGY	1,405,933	1,750,674	3,156,607	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,939,073	17,076,235	20,015,308	54.00
54.01	05401	CARDIAC REHABILITATION	0	370,944	370,944	54.01
56.01	03470	NUCLEAR MEDICINE	760,727	4,826,043	5,586,770	56.01
57.00	05700	CT SCAN	7,554,935	22,869,514	30,424,449	57.00
58.00	05800	MRI	852,950	5,547,812	6,400,762	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,898,442	1,658,812	3,557,254	59.00
60.00	06000	LABORATORY	17,290,296	29,370,466	46,660,762	60.00
64.00	06400	INTRAVENOUS THERAPY	9,921	1,766,486	1,776,407	64.00
65.00	06500	RESPIRATORY THERAPY	4,649,950	1,084,340	5,734,290	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	490,321	490,321	65.98
66.00	06600	PHYSICAL THERAPY	890,293	4,846,479	5,736,772	66.00
68.00	06800	SPEECH PATHOLOGY	105,171	206,472	311,643	68.00
69.00	06900	ELECTROCARDIOLOGY	4,692,045	6,180,985	10,873,030	69.00
70.01	07001	NEUROLOGY	153,233	2,781,700	2,934,933	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,554,131	12,404,668	23,958,799	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	4,479	1,296,992	1,301,471	90.00
90.01	09002	DIABETES EDUCATION	0	10,012	10,012	90.01
90.02	09001	PSYCH SERVICES	1,334	1,300,710	1,302,044	90.02
90.04	09003	ANTI COAGULATION CLINIC	705	470,247	470,952	90.04
91.00	09100	EMERGENCY	5,297,942	16,117,667	21,415,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,877,436	1,877,436	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
200.00		Subtotal (see instructions)	89,090,452	152,520,319	241,610,771	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	89,090,452	152,520,319	241,610,771	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 9:34 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.335392		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.232263		52.00
53.00	05300 ANESTHESIOLOGY	0.102106		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.208414		54.00
54.01	05401 CARDIAC REHABILITATION	0.550579		54.01
56.01	03470 NUCLEAR MEDICINE	0.176530		56.01
57.00	05700 CT SCAN	0.031543		57.00
58.00	05800 MRI	0.051917		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.321990		59.00
60.00	06000 LABORATORY	0.127300		60.00
64.00	06400 INTRAVENOUS THERAPY	0.393243		64.00
65.00	06500 RESPIRATORY THERAPY	0.281001		65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0.244607		65.98
66.00	06600 PHYSICAL THERAPY	0.544566		66.00
68.00	06800 SPEECH PATHOLOGY	0.804234		68.00
69.00	06900 ELECTROCARDIOLOGY	0.160618		69.00
70.01	07001 NEUROLOGY	0.273401		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304174		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.521814		90.00
90.01	09002 DIABETES EDUCATION	4.683480		90.01
90.02	09001 PSYCH SERVICES	0.665653		90.02
90.04	09003 ANTI COAGULATION CLINIC	0.704403		90.04
91.00	09100 EMERGENCY	0.244014		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.261434		92.00
	OTHER REIMBURSABLE COST CENTERS			
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
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: 140034

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 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	14,791,583	14,791,583	0	14,791,583	30.00	
31.00	03100 INTENSIVE CARE UNIT	5,121,194	5,121,194	0	5,121,194	31.00	
40.00	04000 SUBPROVIDER - I/PF	2,042,365	2,042,365	5,981	2,048,346	40.00	
43.00	04300 NURSERY	902,816	902,816	0	902,816	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	8,465,391	8,465,391	27,666	8,493,057	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	812,167	812,167	0	812,167	52.00	
53.00	05300 ANESTHESIOLOGY	291,899	291,899	30,408	322,307	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,163,476	4,163,476	7,996	4,171,472	54.00	
54.01	05401 CARDIAC REHABILITATION	193,599	193,599	10,635	204,234	54.01	
56.01	03470 NUCLEAR MEDICINE	986,234	986,234	0	986,234	56.01	
57.00	05700 CT SCAN	959,666	959,666	0	959,666	57.00	
58.00	05800 MRI	332,310	332,310	0	332,310	58.00	
59.00	05900 CARDIAC CATHETERIZATION	1,133,544	1,133,544	11,856	1,145,400	59.00	
60.00	06000 LABORATORY	5,920,379	5,920,379	19,520	5,939,899	60.00	
64.00	06400 INTRAVENOUS THERAPY	698,559	698,559	0	698,559	64.00	
65.00	06500 RESPIRATORY THERAPY	1,602,666	1,602,666	8,678	1,611,344	65.00	
65.98	06501 HYPERBARIC OXYGEN THERAPY	119,936	119,936	0	119,936	65.98	
66.00	06600 PHYSICAL THERAPY	3,124,049	3,124,049	0	3,124,049	66.00	
68.00	06800 SPEECH PATHOLOGY	250,634	250,634	0	250,634	68.00	
69.00	06900 ELECTROCARDIOLOGY	1,732,198	1,732,198	14,206	1,746,404	69.00	
70.01	07001 NEUROLOGY	791,419	791,419	10,994	802,413	70.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	7,287,646	7,287,646	0	7,287,646	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	679,126	679,126	0	679,126	90.00	
90.01	09002 DIABETES EDUCATION	46,891	46,891	0	46,891	90.01	
90.02	09001 PSYCH SERVICES	866,709	866,709	0	866,709	90.02	
90.04	09003 ANTI COAGULATION CLINIC	331,740	331,740	0	331,740	90.04	
91.00	09100 EMERGENCY	5,225,714	5,225,714	0	5,225,714	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,368,262	2,368,262	0	2,368,262	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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	
200.00	Subtotal (see instructions)	71,242,172	71,242,172	147,940	71,390,112	200.00	
201.00	Less Observation Beds	2,368,262	2,368,262	0	2,368,262	201.00	
202.00	Total (see instructions)	68,873,910	68,873,910	147,940	69,021,850	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140034

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	13,212,481		13,212,481		30.00
31.00	03100	INTENSIVE CARE UNIT	3,088,631		3,088,631		31.00
40.00	04000	SUBPROVIDER - IPF	1,405,835		1,405,835		40.00
43.00	04300	NURSERY	717,725		717,725		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	8,459,590	16,863,183	25,322,773	0.334300	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,144,630	1,352,121	3,496,751	0.232263	52.00
53.00	05300	ANESTHESIOLOGY	1,405,933	1,750,674	3,156,607	0.092472	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,939,073	17,076,235	20,015,308	0.208015	54.00
54.01	05401	CARDIAC REHABILITATION	0	370,944	370,944	0.521909	54.01
56.01	03470	NUCLEAR MEDICINE	760,727	4,826,043	5,586,770	0.176530	56.01
57.00	05700	CT SCAN	7,554,935	22,869,514	30,424,449	0.031543	57.00
58.00	05800	MRI	852,950	5,547,812	6,400,762	0.051917	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,898,442	1,658,812	3,557,254	0.318657	59.00
60.00	06000	LABORATORY	17,290,296	29,370,466	46,660,762	0.126881	60.00
64.00	06400	INTRAVENOUS THERAPY	9,921	1,766,486	1,776,407	0.393243	64.00
65.00	06500	RESPIRATORY THERAPY	4,649,950	1,084,340	5,734,290	0.279488	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	490,321	490,321	0.244607	65.98
66.00	06600	PHYSICAL THERAPY	890,293	4,846,479	5,736,772	0.544566	66.00
68.00	06800	SPEECH PATHOLOGY	105,171	206,472	311,643	0.804234	68.00
69.00	06900	ELECTROCARDIOLOGY	4,692,045	6,180,985	10,873,030	0.159311	69.00
70.01	07001	NEUROLOGY	153,233	2,781,700	2,934,933	0.269655	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,554,131	12,404,668	23,958,799	0.304174	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	4,479	1,296,992	1,301,471	0.521814	90.00
90.01	09002	DIABETES EDUCATION	0	10,012	10,012	4.683480	90.01
90.02	09001	PSYCH SERVICES	1,334	1,300,710	1,302,044	0.665653	90.02
90.04	09003	ANTI COAGULATION CLINIC	705	470,247	470,952	0.704403	90.04
91.00	09100	EMERGENCY	5,297,942	16,117,667	21,415,609	0.244014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,877,436	1,877,436	1.261434	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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
200.00		Subtotal (see instructions)	89,090,452	152,520,319	241,610,771		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	89,090,452	152,520,319	241,610,771		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 9:34 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
	<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.335392		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.232263		52.00
53.00	05300 ANESTHESIOLOGY	0.102106		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.208414		54.00
54.01	05401 CARDIAC REHABILITATION	0.550579		54.01
56.01	03470 NUCLEAR MEDICINE	0.176530		56.01
57.00	05700 CT SCAN	0.031543		57.00
58.00	05800 MRI	0.051917		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.321990		59.00
60.00	06000 LABORATORY	0.127300		60.00
64.00	06400 INTRAVENOUS THERAPY	0.393243		64.00
65.00	06500 RESPIRATORY THERAPY	0.281001		65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0.244607		65.98
66.00	06600 PHYSICAL THERAPY	0.544566		66.00
68.00	06800 SPEECH PATHOLOGY	0.804234		68.00
69.00	06900 ELECTROCARDIOLOGY	0.160618		69.00
70.01	07001 NEUROLOGY	0.273401		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304174		73.00
	<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	0.521814		90.00
90.01	09002 DIABETES EDUCATION	4.683480		90.01
90.02	09001 PSYCH SERVICES	0.665653		90.02
90.04	09003 ANTI COAGULATION CLINIC	0.704403		90.04
91.00	09100 EMERGENCY	0.244014		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.261434		92.00
	<b>OTHER REIMBURSABLE COST CENTERS</b>			
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
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: 140034

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

Worksheet C Part II Date/Time Prepared: 5/29/2015 9:34 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	8,465,391	1,047,438	7,417,953	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	812,167	83,387	728,780	0	0	52.00
53.00	05300	ANESTHESIOLOGY	291,899	35,120	256,779	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,163,476	684,602	3,478,874	0	0	54.00
54.01	05401	CARDIAC REHABILITATION	193,599	12,603	180,996	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	986,234	48,353	937,881	0	0	56.01
57.00	05700	CT SCAN	959,666	141,293	818,373	0	0	57.00
58.00	05800	MRI	332,310	25,523	306,787	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,133,544	63,612	1,069,932	0	0	59.00
60.00	06000	LABORATORY	5,920,379	373,391	5,546,988	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	698,559	77,249	621,310	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,602,666	102,342	1,500,324	0	0	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	119,936	19,163	100,773	0	0	65.98
66.00	06600	PHYSICAL THERAPY	3,124,049	195,051	2,928,998	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	250,634	13,875	236,759	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,732,198	163,604	1,568,594	0	0	69.00
70.01	07001	NEUROLOGY	791,419	58,356	733,063	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,287,646	172,959	7,114,687	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	679,126	34,076	645,050	0	0	90.00
90.01	09002	DIABETES EDUCATION	46,891	1,805	45,086	0	0	90.01
90.02	09001	PSYCH SERVICES	866,709	86,734	779,975	0	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	331,740	13,554	318,186	0	0	90.04
91.00	09100	EMERGENCY	5,225,714	232,264	4,993,450	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	2,368,262	173,939	2,194,323	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
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
200.00		Subtotal (sum of lines 50 thru 199)	48,384,214	3,860,293	44,523,921	0	0	200.00
201.00		Less Observation Beds	2,368,262	173,939	2,194,323	0	0	201.00
202.00		Total (line 200 minus line 201)	46,015,952	3,686,354	42,329,598	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Prepared: 5/29/2015 9:34 am
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	8,465,391	25,322,773	0.334300		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	812,167	3,496,751	0.232263		52.00
53.00	05300 ANESTHESIOLOGY	291,899	3,156,607	0.092472		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,163,476	20,015,308	0.208015		54.00
54.01	05401 CARDIAC REHABILITATION	193,599	370,944	0.521909		54.01
56.01	03470 NUCLEAR MEDICINE	986,234	5,586,770	0.176530		56.01
57.00	05700 CT SCAN	959,666	30,424,449	0.031543		57.00
58.00	05800 MRI	332,310	6,400,762	0.051917		58.00
59.00	05900 CARDIAC CATHETERIZATION	1,133,544	3,557,254	0.318657		59.00
60.00	06000 LABORATORY	5,920,379	46,660,762	0.126881		60.00
64.00	06400 INTRAVENOUS THERAPY	698,559	1,776,407	0.393243		64.00
65.00	06500 RESPIRATORY THERAPY	1,602,666	5,734,290	0.279488		65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	119,936	490,321	0.244607		65.98
66.00	06600 PHYSICAL THERAPY	3,124,049	5,736,772	0.544566		66.00
68.00	06800 SPEECH PATHOLOGY	250,634	311,643	0.804234		68.00
69.00	06900 ELECTROCARDIOLOGY	1,732,198	10,873,030	0.159311		69.00
70.01	07001 NEUROLOGY	791,419	2,934,933	0.269655		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,287,646	23,958,799	0.304174		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	679,126	1,301,471	0.521814		90.00
90.01	09002 DIABETES EDUCATION	46,891	10,012	4.683480		90.01
90.02	09001 PSYCH SERVICES	866,709	1,302,044	0.665653		90.02
90.04	09003 ANTI COAGULATION CLINIC	331,740	470,952	0.704403		90.04
91.00	09100 EMERGENCY	5,225,714	21,415,609	0.244014		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,368,262	1,877,436	1.261434		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
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
200.00	Subtotal (sum of lines 50 thru 199)	48,384,214	223,186,099			200.00
201.00	Less Observation Beds	2,368,262	0			201.00
202.00	Total (line 200 minus line 201)	46,015,952	223,186,099			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/29/2015 9:34 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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,086,384	0	1,086,384	16,139	67.31	30.00
31.00	INTENSIVE CARE UNIT	359,044		359,044	2,392	150.10	31.00
40.00	SUBPROVIDER - IPF	99,875	0	99,875	2,103	47.49	40.00
43.00	NURSERY	67,782		67,782	604	112.22	43.00
200.00	Total (Lines 30-199)	1,613,085		1,613,085	21,238		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	8,823	593,876				
31.00	INTENSIVE CARE UNIT	1,542	231,454				
40.00	SUBPROVIDER - IPF	382	18,141				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	10,747	843,471				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 9:34 am
		Title XVIII		Hospital
				PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,047,438	25,322,773	0.041363	4,289,078	177,409	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	83,387	3,496,751	0.023847	32,131	766	52.00
53.00	05300 ANESTHESIOLOGY	35,120	3,156,607	0.011126	398,482	4,434	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	684,602	20,015,308	0.034204	1,831,259	62,636	54.00
54.01	05401 CARDIAC REHABILITATION	12,603	370,944	0.033975	0	0	54.01
56.01	03470 NUCLEAR MEDICINE	48,353	5,586,770	0.008655	457,832	3,963	56.01
57.00	05700 CT SCAN	141,293	30,424,449	0.004644	4,344,586	20,176	57.00
58.00	05800 MRI	25,523	6,400,762	0.003987	469,479	1,872	58.00
59.00	05900 CARDIAC CATHETERIZATION	63,612	3,557,254	0.017882	1,091,313	19,515	59.00
60.00	06000 LABORATORY	373,391	46,660,762	0.008002	9,768,907	78,171	60.00
64.00	06400 INTRAVENOUS THERAPY	77,249	1,776,407	0.043486	9,659	420	64.00
65.00	06500 RESPIRATORY THERAPY	102,342	5,734,290	0.017847	3,192,970	56,985	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	19,163	490,321	0.039083	0	0	65.98
66.00	06600 PHYSICAL THERAPY	195,051	5,736,772	0.034000	688,279	23,401	66.00
68.00	06800 SPEECH PATHOLOGY	13,875	311,643	0.044522	78,804	3,509	68.00
69.00	06900 ELECTROCARDIOLOGY	163,604	10,873,030	0.015047	3,331,342	50,127	69.00
70.01	07001 NEUROLOGY	58,356	2,934,933	0.019883	102,048	2,029	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	172,959	23,958,799	0.007219	7,066,768	51,015	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	34,076	1,301,471	0.026183	0	0	90.00
90.01	09002 DIABETES EDUCATION	1,805	10,012	0.180284	0	0	90.01
90.02	09001 PSYCH SERVICES	86,734	1,302,044	0.066614	0	0	90.02
90.04	09003 ANTI COAGULATION CLINIC	13,554	470,952	0.028780	357	10	90.04
91.00	09100 EMERGENCY	232,264	21,415,609	0.010846	2,955,111	32,051	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	173,939	1,877,436	0.092647	0	0	92.00
200.00	Total (Lines 50-199)	3,860,293	223,186,099		40,108,405	588,489	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/29/2015 9:34 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	16,139	0.00	8,823	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,392	0.00	1,542	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,103	0.00	382	0		40.00
43.00	04300	NURSERY	604	0.00	0	0		43.00
200.00		Total (lines 30-199)	21,238		10,747	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:34 am
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
<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
54.01	05401	CARDIAC REHABILITATION	0	0	0	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	65.98
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.01	07001	NEUROLOGY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	DIABETES EDUCATION	0	0	0	0	0	90.01
90.02	09001	PSYCH SERVICES	0	0	0	0	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
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: 140034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2015 9:34 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	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	25,322,773	0.000000	0.000000	4,289,078	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,496,751	0.000000	0.000000	32,131	52.00
53.00	05300	ANESTHESIOLOGY	0	3,156,607	0.000000	0.000000	398,482	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,015,308	0.000000	0.000000	1,831,259	54.00
54.01	05401	CARDIAC REHABILITATION	0	370,944	0.000000	0.000000	0	54.01
56.01	03470	NUCLEAR MEDICINE	0	5,586,770	0.000000	0.000000	457,832	56.01
57.00	05700	CT SCAN	0	30,424,449	0.000000	0.000000	4,344,586	57.00
58.00	05800	MRI	0	6,400,762	0.000000	0.000000	469,479	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,557,254	0.000000	0.000000	1,091,313	59.00
60.00	06000	LABORATORY	0	46,660,762	0.000000	0.000000	9,768,907	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,776,407	0.000000	0.000000	9,659	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,734,290	0.000000	0.000000	3,192,970	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	0	490,321	0.000000	0.000000	0	65.98
66.00	06600	PHYSICAL THERAPY	0	5,736,772	0.000000	0.000000	688,279	66.00
68.00	06800	SPEECH PATHOLOGY	0	311,643	0.000000	0.000000	78,804	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,873,030	0.000000	0.000000	3,331,342	69.00
70.01	07001	NEUROLOGY	0	2,934,933	0.000000	0.000000	102,048	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,958,799	0.000000	0.000000	7,066,768	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1,301,471	0.000000	0.000000	0	90.00
90.01	09002	DIABETES EDUCATION	0	10,012	0.000000	0.000000	0	90.01
90.02	09001	PSYCH SERVICES	0	1,302,044	0.000000	0.000000	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	470,952	0.000000	0.000000	357	90.04
91.00	09100	EMERGENCY	0	21,415,609	0.000000	0.000000	2,955,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,877,436	0.000000	0.000000	0	92.00
200.00		Total (Lines 50-199)	0	223,186,099			40,108,405	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2015 9:34 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	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	5,223,130	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	16,623	0	52.00
53.00	05300 ANESTHESIOLOGY	0	483,158	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,875,249	0	54.00
54.01	05401 CARDIAC REHABILITATION	0	241,664	0	54.01
56.01	03470 NUCLEAR MEDICINE	0	1,813,623	0	56.01
57.00	05700 CT SCAN	0	8,015,124	0	57.00
58.00	05800 MRI	0	1,681,297	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	904,161	0	59.00
60.00	06000 LABORATORY	0	5,588,627	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,130,293	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	432,773	0	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0	153,052	0	65.98
66.00	06600 PHYSICAL THERAPY	0	703	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,863,471	0	69.00
70.01	07001 NEUROLOGY	0	764,469	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,919,856	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	756,713	0	90.00
90.01	09002 DIABETES EDUCATION	0	104	0	90.01
90.02	09001 PSYCH SERVICES	0	143	0	90.02
90.04	09003 ANTI COAGULATION CLINIC	0	270,491	0	90.04
91.00	09100 EMERGENCY	0	3,559,197	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	2,019,149	0	92.00
200.00	Total (Lines 50-199)	0	48,713,070	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 9:34 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.334300	5,223,130	0	0	1,746,092	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.232263	16,623	0	0	3,861	52.00
53.00	05300 ANESTHESIOLOGY	0.092472	483,158	0	0	44,679	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.208015	5,875,249	0	583	1,222,140	54.00
54.01	05401 CARDIAC REHABILITATION	0.521909	241,664	0	0	126,127	54.01
56.01	03470 NUCLEAR MEDICINE	0.176530	1,813,623	0	0	320,159	56.01
57.00	05700 CT SCAN	0.031543	8,015,124	0	8,208	252,821	57.00
58.00	05800 MRI	0.051917	1,681,297	0	2,449	87,288	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.318657	904,161	0	0	288,117	59.00
60.00	06000 LABORATORY	0.126881	5,588,627	4,323	0	709,091	60.00
64.00	06400 INTRAVENOUS THERAPY	0.393243	1,130,293	0	0	444,480	64.00
65.00	06500 RESPIRATORY THERAPY	0.279488	432,773	18	0	120,955	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0.244607	153,052	0	0	37,438	65.98
66.00	06600 PHYSICAL THERAPY	0.544566	703	0	0	383	66.00
68.00	06800 SPEECH PATHOLOGY	0.804234	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.159311	2,863,471	0	0	456,182	69.00
70.01	07001 NEUROLOGY	0.269655	764,469	0	0	206,143	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304174	6,919,856	0	166,847	2,104,840	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.521814	756,713	0	128	394,863	90.00
90.01	09002 DIABETES EDUCATION	4.683480	104	0	0	487	90.01
90.02	09001 PSYCH SERVICES	0.665653	143	0	0	95	90.02
90.04	09003 ANTI COAGULATION CLINIC	0.704403	270,491	0	0	190,535	90.04
91.00	09100 EMERGENCY	0.244014	3,559,197	0	0	868,494	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.261434	2,019,149	0	0	2,547,023	92.00
200.00	Subtotal (see instructions)		48,713,070	4,341	178,215	12,172,293	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		48,713,070	4,341	178,215	12,172,293	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 9:34 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<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	121		54.00
54.01 05401 CARDIAC REHABILITATION	0	0		54.01
56.01 03470 NUCLEAR MEDICINE	0	0		56.01
57.00 05700 CT SCAN	0	259		57.00
58.00 05800 MRI	0	127		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	549	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	5	0		65.00
65.98 06501 HYPERBARIC OXYGEN THERAPY	0	0		65.98
66.00 06600 PHYSICAL THERAPY	0	0		66.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.01 07001 NEUROLOGY	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	50,751		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	67		90.00
90.01 09002 DIABETES EDUCATION	0	0		90.01
90.02 09001 PSYCH SERVICES	0	0		90.02
90.04 09003 ANTI COAGULATION CLINIC	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00 Subtotal (see instructions)	554	51,325		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	554	51,325		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140034 Component CCN: 14S034		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/29/2015 9:34 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,047,438	25,322,773	0.041363	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83,387	3,496,751	0.023847	0	52.00
53.00	05300	ANESTHESIOLOGY	35,120	3,156,607	0.011126	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	684,602	20,015,308	0.034204	8,019	54.00
54.01	05401	CARDIAC REHABILITATION	12,603	370,944	0.033975	0	54.01
56.01	03470	NUCLEAR MEDICINE	48,353	5,586,770	0.008655	0	56.01
57.00	05700	CT SCAN	141,293	30,424,449	0.004644	36,595	57.00
58.00	05800	MRI	25,523	6,400,762	0.003987	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	63,612	3,557,254	0.017882	0	59.00
60.00	06000	LABORATORY	373,391	46,660,762	0.008002	308,517	60.00
64.00	06400	INTRAVENOUS THERAPY	77,249	1,776,407	0.043486	0	64.00
65.00	06500	RESPIRATORY THERAPY	102,342	5,734,290	0.017847	3,608	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	19,163	490,321	0.039083	0	65.98
66.00	06600	PHYSICAL THERAPY	195,051	5,736,772	0.034000	0	66.00
68.00	06800	SPEECH PATHOLOGY	13,875	311,643	0.044522	0	68.00
69.00	06900	ELECTROCARDIOLOGY	163,604	10,873,030	0.015047	2,910	69.00
70.01	07001	NEUROLOGY	58,356	2,934,933	0.019883	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,959	23,958,799	0.007219	42,804	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	34,076	1,301,471	0.026183	0	90.00
90.01	09002	DIABETES EDUCATION	1,805	10,012	0.180284	0	90.01
90.02	09001	PSYCH SERVICES	86,734	1,302,044	0.066614	821	90.02
90.04	09003	ANTI COAGULATION CLINIC	13,554	470,952	0.028780	0	90.04
91.00	09100	EMERGENCY	232,264	21,415,609	0.010846	89,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,877,436	0.000000	0	92.00
200.00		Total (lines 50-199)	3,686,354	223,186,099		492,419	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:34 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<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
54.01	05401 CARDIAC REHABILITATION	0	0	0	0	0	54.01
56.01	03470 NUCLEAR MEDICINE	0	0	0	0	0	56.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	65.98
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.01	07001 NEUROLOGY	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09002 DIABETES EDUCATION	0	0	0	0	0	90.01
90.02	09001 PSYCH SERVICES	0	0	0	0	0	90.02
90.04	09003 ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
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: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:34 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	25,322,773	0.000000	0.000000	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3,496,751	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	3,156,607	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	20,015,308	0.000000	0.000000	8,019 54.00
54.01 05401 CARDIAC REHABILITATION	0	370,944	0.000000	0.000000	0 54.01
56.01 03470 NUCLEAR MEDICINE	0	5,586,770	0.000000	0.000000	0 56.01
57.00 05700 CT SCAN	0	30,424,449	0.000000	0.000000	36,595 57.00
58.00 05800 MRI	0	6,400,762	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	3,557,254	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	46,660,762	0.000000	0.000000	308,517 60.00
64.00 06400 INTRAVENOUS THERAPY	0	1,776,407	0.000000	0.000000	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	5,734,290	0.000000	0.000000	3,608 65.00
65.98 06501 HYPERBARIC OXYGEN THERAPY	0	490,321	0.000000	0.000000	0 65.98
66.00 06600 PHYSICAL THERAPY	0	5,736,772	0.000000	0.000000	0 66.00
68.00 06800 SPEECH PATHOLOGY	0	311,643	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	10,873,030	0.000000	0.000000	2,910 69.00
70.01 07001 NEUROLOGY	0	2,934,933	0.000000	0.000000	0 70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0.000000	0 71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	23,958,799	0.000000	0.000000	42,804 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	1,301,471	0.000000	0.000000	0 90.00
90.01 09002 DIABETES EDUCATION	0	10,012	0.000000	0.000000	0 90.01
90.02 09001 PSYCH SERVICES	0	1,302,044	0.000000	0.000000	821 90.02
90.04 09003 ANTI COAGULATION CLINIC	0	470,952	0.000000	0.000000	0 90.04
91.00 09100 EMERGENCY	0	21,415,609	0.000000	0.000000	89,145 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	1,877,436	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	223,186,099			492,419 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:34 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
<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
54.01	05401	CARDIAC REHABILITATION	0	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	0	0	0	56.01
57.00	05700	CT SCAN	0	2,000	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	0	65.98
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.01	07001	NEUROLOGY	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	705	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09002	DIABETES EDUCATION	0	0	0	90.01
90.02	09001	PSYCH SERVICES	0	261,394	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	92.00
200.00		Total (lines 50-199)	0	264,099	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 9:34 am
	Title XVIII	Subprovider - IPF	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	0.334300	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.232263	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.092472	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.208015	0	0	0	0	54.00
54.01 05401 CARDIAC REHABILITATION	0.521909	0	0	0	0	54.01
56.01 03470 NUCLEAR MEDICINE	0.176530	0	0	0	0	56.01
57.00 05700 CT SCAN	0.031543	2,000	0	0	63	57.00
58.00 05800 MRI	0.051917	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.318657	0	0	0	0	59.00
60.00 06000 LABORATORY	0.126881	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.393243	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.279488	0	0	0	0	65.00
65.98 06501 HYPERBARIC OXYGEN THERAPY	0.244607	0	0	0	0	65.98
66.00 06600 PHYSICAL THERAPY	0.544566	0	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0.804234	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.159311	0	0	0	0	69.00
70.01 07001 NEUROLOGY	0.269655	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.304174	705	0	1,026	214	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.521814	0	0	0	0	90.00
90.01 09002 DIABETES EDUCATION	4.683480	0	0	0	0	90.01
90.02 09001 PSYCH SERVICES	0.665653	261,394	0	0	173,998	90.02
90.04 09003 ANTI COAGULATION CLINIC	0.704403	0	0	0	0	90.04
91.00 09100 EMERGENCY	0.244014	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	1.261434	0	0	0	0	92.00
200.00 Subtotal (see instructions)		264,099	0	1,026	174,275	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		264,099	0	1,026	174,275	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 9:34 am
	Title XVII I	Subprovider - IPF	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	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 CARDIAC REHABILITATION	0	0	54.01
56.01 03470 NUCLEAR MEDICINE	0	0	56.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
65.98 06501 HYPERBARI C OXYGEN THERAPY	0	0	65.98
66.00 06600 PHYSICAL THERAPY	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.01 07001 NEUROLOGY	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	312	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
90.01 09002 DIABETES EDUCATION	0	0	90.01
90.02 09001 PSYCH SERVICES	0	0	90.02
90.04 09003 ANTI COAGULATION CLINIC	0	0	90.04
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
200.00 Subtotal (see instructions)	0	312	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	312	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I Date/Time Prepared: 5/29/2015 9:34 am
		Title XIX	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,086,384	0	1,086,384	16,139	67.31	30.00	
31.00	INTENSIVE CARE UNIT	359,044		359,044	2,392	150.10	31.00	
40.00	SUBPROVIDER - IPF	99,875	0	99,875	2,103	47.49	40.00	
43.00	NURSERY	67,782		67,782	604	112.22	43.00	
200.00	Total (lines 30-199)	1,613,085		1,613,085	21,238		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,303	155,015					30.00
31.00	INTENSIVE CARE UNIT	426	63,943					31.00
40.00	SUBPROVIDER - IPF	1,361	64,634					40.00
43.00	NURSERY	524	58,803					43.00
200.00	Total (lines 30-199)	4,614	342,395					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 9:34 am
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Cost Center Description		Title XIX			Hospital	PPS
		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	1,047,438	25,322,773	0.041363	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	83,387	3,496,751	0.023847	0	0
53.00	05300 ANESTHESIOLOGY	35,120	3,156,607	0.011126	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	684,602	20,015,308	0.034204	0	0
54.01	05401 CARDIAC REHABILITATION	12,603	370,944	0.033975	0	0
56.01	03470 NUCLEAR MEDICINE	48,353	5,586,770	0.008655	0	0
57.00	05700 CT SCAN	141,293	30,424,449	0.004644	0	0
58.00	05800 MRI	25,523	6,400,762	0.003987	0	0
59.00	05900 CARDIAC CATHETERIZATION	63,612	3,557,254	0.017882	0	0
60.00	06000 LABORATORY	373,391	46,660,762	0.008002	0	0
64.00	06400 INTRAVENOUS THERAPY	77,249	1,776,407	0.043486	0	0
65.00	06500 RESPIRATORY THERAPY	102,342	5,734,290	0.017847	0	0
65.98	06501 HYPERBARI C OXYGEN THERAPY	19,163	490,321	0.039083	0	0
66.00	06600 PHYSICAL THERAPY	195,051	5,736,772	0.034000	0	0
68.00	06800 SPEECH PATHOLOGY	13,875	311,643	0.044522	0	0
69.00	06900 ELECTROCARDIOLOGY	163,604	10,873,030	0.015047	0	0
70.01	07001 NEUROLOGY	58,356	2,934,933	0.019883	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	172,959	23,958,799	0.007219	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	34,076	1,301,471	0.026183	0	0
90.01	09002 DIABETES EDUCATION	1,805	10,012	0.180284	0	0
90.02	09001 PSYCH SERVICES	86,734	1,302,044	0.066614	0	0
90.04	09003 ANTI COAGULATION CLINIC	13,554	470,952	0.028780	0	0
91.00	09100 EMERGENCY	232,264	21,415,609	0.010846	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	173,939	1,877,436	0.092647	0	0
200.00	Total (Lines 50-199)	3,860,293	223,186,099		0	0

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part III Date/Time Prepared: 5/29/2015 9:34 am
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Cost Center Description			Title XIX				Hospital	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	16,139	0.00	2,303	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,392	0.00	426	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,103	0.00	1,361	0		40.00
43.00	04300	NURSERY	604	0.00	524	0		43.00
200.00		Total (lines 30-199)	21,238		4,614	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2015 9:34 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		
<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
54.01	05401	CARDIAC REHABILITATION	0	0	0	0	0	54.01
56.01	03470	NUCLEAR MEDICINE	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	65.98
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.01	07001	NEUROLOGY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	DIABETES EDUCATION	0	0	0	0	0	90.01
90.02	09001	PSYCH SERVICES	0	0	0	0	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
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: 140034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2015 9:34 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			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	25,322,773	0.000000	0.000000		0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,496,751	0.000000	0.000000		0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,156,607	0.000000	0.000000		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,015,308	0.000000	0.000000		0	54.00
54.01	05401	CARDIAC REHABILITATION	0	370,944	0.000000	0.000000		0	54.01
56.01	03470	NUCLEAR MEDICINE	0	5,586,770	0.000000	0.000000		0	56.01
57.00	05700	CT SCAN	0	30,424,449	0.000000	0.000000		0	57.00
58.00	05800	MRI	0	6,400,762	0.000000	0.000000		0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,557,254	0.000000	0.000000		0	59.00
60.00	06000	LABORATORY	0	46,660,762	0.000000	0.000000		0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,776,407	0.000000	0.000000		0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,734,290	0.000000	0.000000		0	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	0	490,321	0.000000	0.000000		0	65.98
66.00	06600	PHYSICAL THERAPY	0	5,736,772	0.000000	0.000000		0	66.00
68.00	06800	SPEECH PATHOLOGY	0	311,643	0.000000	0.000000		0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,873,030	0.000000	0.000000		0	69.00
70.01	07001	NEUROLOGY	0	2,934,933	0.000000	0.000000		0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0.000000		0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,958,799	0.000000	0.000000		0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	1,301,471	0.000000	0.000000		0	90.00
90.01	09002	DIABETES EDUCATION	0	10,012	0.000000	0.000000		0	90.01
90.02	09001	PSYCH SERVICES	0	1,302,044	0.000000	0.000000		0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0	470,952	0.000000	0.000000		0	90.04
91.00	09100	EMERGENCY	0	21,415,609	0.000000	0.000000		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,877,436	0.000000	0.000000		0	92.00
200.00		Total (Lines 50-199)	0	223,186,099				0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2015 9:34 am

Cost Center Description		Title XIX			Hospital	PPS
		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
54.01	05401 CARDIAC REHABILITATION	0	0	0		54.01
56.01	03470 NUCLEAR MEDICINE	0	0	0		56.01
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0	0	0		65.98
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.01	07001 NEUROLOGY	0	0	0		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09002 DIABETES EDUCATION	0	0	0		90.01
90.02	09001 PSYCH SERVICES	0	0	0		90.02
90.04	09003 ANTI COAGULATION CLINIC	0	0	0		90.04
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0		92.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140034 Component CCN: 14S034		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/29/2015 9:34 am	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,047,438	25,322,773	0.041363	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83,387	3,496,751	0.023847	0	0 52.00
53.00	05300	ANESTHESIOLOGY	35,120	3,156,607	0.011126	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	684,602	20,015,308	0.034204	0	0 54.00
54.01	05401	CARDIAC REHABILITATION	12,603	370,944	0.033975	0	0 54.01
56.01	03470	NUCLEAR MEDICINE	48,353	5,586,770	0.008655	0	0 56.01
57.00	05700	CT SCAN	141,293	30,424,449	0.004644	0	0 57.00
58.00	05800	MRI	25,523	6,400,762	0.003987	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	63,612	3,557,254	0.017882	0	0 59.00
60.00	06000	LABORATORY	373,391	46,660,762	0.008002	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	77,249	1,776,407	0.043486	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	102,342	5,734,290	0.017847	0	0 65.00
65.98	06501	HYPERBARIC OXYGEN THERAPY	19,163	490,321	0.039083	0	0 65.98
66.00	06600	PHYSICAL THERAPY	195,051	5,736,772	0.034000	0	0 66.00
68.00	06800	SPEECH PATHOLOGY	13,875	311,643	0.044522	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	163,604	10,873,030	0.015047	0	0 69.00
70.01	07001	NEUROLOGY	58,356	2,934,933	0.019883	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,959	23,958,799	0.007219	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	34,076	1,301,471	0.026183	0	0 90.00
90.01	09002	DIABETES EDUCATION	1,805	10,012	0.180284	0	0 90.01
90.02	09001	PSYCH SERVICES	86,734	1,302,044	0.066614	0	0 90.02
90.04	09003	ANTI COAGULATION CLINIC	13,554	470,952	0.028780	0	0 90.04
91.00	09100	EMERGENCY	232,264	21,415,609	0.010846	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,877,436	0.000000	0	0 92.00
200.00		Total (lines 50-199)	3,686,354	223,186,099		0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:34 am
	Title XIX	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<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
54.01	05401 CARDIAC REHABILITATION	0	0	0	0	0	54.01
56.01	03470 NUCLEAR MEDICINE	0	0	0	0	0	56.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	65.98
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.01	07001 NEUROLOGY	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09002 DIABETES EDUCATION	0	0	0	0	0	90.01
90.02	09001 PSYCH SERVICES	0	0	0	0	0	90.02
90.04	09003 ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
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: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:34 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	25,322,773	0.000000	0.000000	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3,496,751	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	3,156,607	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	20,015,308	0.000000	0.000000	0 54.00
54.01 05401 CARDIAC REHABILITATION	0	370,944	0.000000	0.000000	0 54.01
56.01 03470 NUCLEAR MEDICINE	0	5,586,770	0.000000	0.000000	0 56.01
57.00 05700 CT SCAN	0	30,424,449	0.000000	0.000000	0 57.00
58.00 05800 MRI	0	6,400,762	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	3,557,254	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	46,660,762	0.000000	0.000000	0 60.00
64.00 06400 INTRAVENOUS THERAPY	0	1,776,407	0.000000	0.000000	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	5,734,290	0.000000	0.000000	0 65.00
65.98 06501 HYPERBARIC OXYGEN THERAPY	0	490,321	0.000000	0.000000	0 65.98
66.00 06600 PHYSICAL THERAPY	0	5,736,772	0.000000	0.000000	0 66.00
68.00 06800 SPEECH PATHOLOGY	0	311,643	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	10,873,030	0.000000	0.000000	0 69.00
70.01 07001 NEUROLOGY	0	2,934,933	0.000000	0.000000	0 70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0.000000	0 71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	23,958,799	0.000000	0.000000	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	1,301,471	0.000000	0.000000	0 90.00
90.01 09002 DIABETES EDUCATION	0	10,012	0.000000	0.000000	0 90.01
90.02 09001 PSYCH SERVICES	0	1,302,044	0.000000	0.000000	0 90.02
90.04 09003 ANTI COAGULATION CLINIC	0	470,952	0.000000	0.000000	0 90.04
91.00 09100 EMERGENCY	0	21,415,609	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	1,877,436	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	223,186,099			0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 9:34 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
<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
54.01 05401 CARDIAC REHABILITATION	0	0	0	54.01
56.01 03470 NUCLEAR MEDICINE	0	0	0	56.01
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MRI	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
65.98 06501 HYPERBARIC OXYGEN THERAPY	0	0	0	65.98
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.01 07001 NEUROLOGY	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09002 DIABETES EDUCATION	0	0	0	90.01
90.02 09001 PSYCH SERVICES	0	0	0	90.02
90.04 09003 ANTI COAGULATION CLINIC	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2015 9:34 am
Cost Center Description				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)		16,139	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,139	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.		13,525	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		30	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		8,823	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,791,583	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		14,791,583	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)		14,791,583	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)		916.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,086,368	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)		8,086,368	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/29/2015 9:34 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	5,121,194	2,392	2,140.97	1,542	3,301,376		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)					8,478,597		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					19,866,341		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)					825,330		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					588,489		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,413,819		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					18,452,522		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)					2,584		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					916.51		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,368,262		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:34 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	1,086,384	14,791,583	0.073446	2,368,262	173,939	90.00
91.00	Nursing School cost	0	14,791,583	0.000000	2,368,262	0	91.00
92.00	Allied health cost	0	14,791,583	0.000000	2,368,262	0	92.00
93.00	All other Medical Education	0	14,791,583	0.000000	2,368,262	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 14S034		Date/Time Prepared: 5/29/2015 9:34 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				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)		2,103	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,103	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)		2,103	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		382	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,048,346	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,048,346	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)		2,048,346	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)		974.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		372,072	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)		372,072	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 14S034				Date/Time Prepared: 5/29/2015 9:34 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					78,900		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					450,972		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					18,141		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,352		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					22,493		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					428,479		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034 Component CCN: 14S034		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:34 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	99,875	2,048,346	0.048759	0	0	90.00
91.00	Nursing School cost	0	2,048,346	0.000000	0	0	91.00
92.00	Allied health cost	0	2,048,346	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,048,346	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2015 9:34 am
Cost Center Description				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)		16,139	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,139	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)		13,555	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,303	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)		604	15.00
16.00	Nursery days (title V or XIX only)		524	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,791,583	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		14,791,583	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)		14,791,583	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)		916.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,110,723	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,110,723	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 9:34 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)	902,816	604	1,494.73	524	783,239	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,121,194	2,392	2,140.97	426	912,053	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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,806,015	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)					277,761	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)					277,761	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,528,254	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)					2,584	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					916.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,368,262	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:34 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,086,384	14,791,583	0.073446	2,368,262	173,939	90.00
91.00	Nursing School cost	0	14,791,583	0.000000	2,368,262	0	91.00
92.00	Allied health cost	0	14,791,583	0.000000	2,368,262	0	92.00
93.00	All other Medical Education	0	14,791,583	0.000000	2,368,262	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 14S034		Date/Time Prepared: 5/29/2015 9:34 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description				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)		2,103	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,103	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)		2,103	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,361	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)		604	15.00
16.00	Nursery days (title V or XIX only)		524	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,048,346	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,048,346	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)		2,048,346	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)		974.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,325,628	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)		1,325,628	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 14S034		Date/Time Prepared: 5/29/2015 9:34 am			
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,325,628	49.00	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					64,634	50.00	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	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					64,634	52.00	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,260,994	53.00	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0	54.00	54.00
55.00 Target amount per discharge					0.00	55.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	57.00
58.00 Bonus payment (see instructions)					0	58.00	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	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	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	61.00
62.00 Relief payment (see instructions)					0	62.00	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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	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	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	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	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	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	71.00
72.00 Program routine service cost (line 9 x line 71)						72.00	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	80.00
81.00 Inpatient routine service cost per diem limitation						81.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	83.00
84.00 Program inpatient ancillary services (see instructions)						84.00	84.00
85.00 Utilization review - physician compensation (see instructions)						85.00	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0	87.00	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140034 Component CCN: 14S034		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 9:34 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	99,875	2,048,346	0.048759	0	0	90.00
91.00	Nursing School cost	0	2,048,346	0.000000	0	0	91.00
92.00	Allied health cost	0	2,048,346	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,048,346	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/29/2015 9:34 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		6,807,222	30.00
31.00	03100	INTENSIVE CARE UNIT		1,925,271	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.335392	4,289,078	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.232263	32,131	52.00
53.00	05300	ANESTHESIOLOGY	0.102106	398,482	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208414	1,831,259	54.00
54.01	05401	CARDIAC REHABILITATION	0.550579	0	54.01
56.01	03470	NUCLEAR MEDICINE	0.176530	457,832	56.01
57.00	05700	CT SCAN	0.031543	4,344,586	57.00
58.00	05800	MRI	0.051917	469,479	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.321990	1,091,313	59.00
60.00	06000	LABORATORY	0.127300	9,768,907	60.00
64.00	06400	INTRAVENOUS THERAPY	0.393243	9,659	64.00
65.00	06500	RESPIRATORY THERAPY	0.281001	3,192,970	65.00
65.98	06501	HYPERBARI C OXYGEN THERAPY	0.244607	0	65.98
66.00	06600	PHYSICAL THERAPY	0.544566	688,279	66.00
68.00	06800	SPEECH PATHOLOGY	0.804234	78,804	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160618	3,331,342	69.00
70.01	07001	NEUROLOGY	0.273401	102,048	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304174	7,066,768	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.521814	0	90.00
90.01	09002	DIABETES EDUCATION	4.683480	0	90.01
90.02	09001	PSYCH SERVICES	0.665653	0	90.02
90.04	09003	ANTI COAGULATION CLINIC	0.704403	357	90.04
91.00	09100	EMERGENCY	0.244014	2,955,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.261434	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		40,108,405	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		40,108,405	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/29/2015 9:34 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		254,579	40.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.335392	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.232263	0	52.00
53.00	05300 ANESTHESIOLOGY	0.102106	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.208414	8,019	54.00
54.01	05401 CARDIAC REHABILITATION	0.550579	0	54.01
56.01	03470 NUCLEAR MEDICINE	0.176530	0	56.01
57.00	05700 CT SCAN	0.031543	36,595	57.00
58.00	05800 MRI	0.051917	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.321990	0	59.00
60.00	06000 LABORATORY	0.127300	308,517	60.00
64.00	06400 INTRAVENOUS THERAPY	0.393243	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.281001	3,608	65.00
65.98	06501 HYPERBARIC OXYGEN THERAPY	0.244607	0	65.98
66.00	06600 PHYSICAL THERAPY	0.544566	0	66.00
68.00	06800 SPEECH PATHOLOGY	0.804234	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.160618	2,910	69.00
70.01	07001 NEUROLOGY	0.273401	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304174	42,804	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.521814	0	90.00
90.01	09002 DIABETES EDUCATION	4.683480	0	90.01
90.02	09001 PSYCH SERVICES	0.665653	821	90.02
90.04	09003 ANTI COAGULATION CLINIC	0.704403	0	90.04
91.00	09100 EMERGENCY	0.244014	89,145	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.261434	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		492,419	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		492,419	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 9:34 am
		Title XVIII	Hospital	PPS
		0	1.00	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		11,661,135	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,867,876	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		98,650	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		88.29	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.04	31.00
32.00	Sum of lines 30 and 31		28.41	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.66	33.00
34.00	Disproportionate share adjustment (see instructions)		491,493	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 9:34 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000147050	0.000130055	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,330,270	994,613	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		994,969	250,697	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,245,666		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		17,364,820		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		18,286,655		48.00
49.00	Total payment for inpatient operating costs (see instructions)		18,056,196		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,236,166		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		19,292,362		59.00
60.00	Primary payer payments		17,678		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		19,274,684		61.00
62.00	Deductibles billed to program beneficiaries		1,979,102		62.00
63.00	Coinurance billed to program beneficiaries		76,880		63.00
64.00	Allowable bad debts (see instructions)		467,033		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		303,571		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		303,571		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		17,522,273		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		82,505		70.93
70.94	HRR adjustment amount (see instructions)		-248,419		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 9:34 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,356,359		71.00
71.01	Sequestration adjustment (see instructions)		347,127		71.01
72.00	Interim payments		17,365,461		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-356,229		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		100,000		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		517,111	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 9:34 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		51,879	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,172,293	2.00
3.00	PPS payments		8,821,671	3.00
4.00	Outlier payment (see instructions)		11,183	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)		51,879	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		182,556	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)		182,556	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)		182,556	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		130,677	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)		51,879	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)		8,832,854	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,923,730	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)		6,961,003	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)		6,961,003	30.00
31.00	Primary payer payments		601	31.00
32.00	Subtotal (line 30 minus line 31)		6,960,402	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)		258,235	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		167,853	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		167,853	36.00
37.00	Subtotal (see instructions)		7,128,255	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,128,255	40.00
40.01	Sequestration adjustment (see instructions)		142,565	40.01
41.00	Interim payments		6,809,376	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		176,314	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034 Component CCN: 14S034	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 9:34 am
		Title XVII	Subprovider - IPF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			312 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			174,275 2.00
3.00	PPS payments			99,558 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)			312 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			1,026 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)			1,026 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)			1,026 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			714 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)			312 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)			99,558 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			21,520 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			0 26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			78,350 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)			78,350 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			78,350 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)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			78,350 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)			78,350 40.00
40.01	Sequestration adjustment (see instructions)			1,567 40.01
41.00	Interim payments			76,839 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-56 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: 140034

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		17,365,461		6,809,376	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		17,365,461		6,809,376	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		176,314	6.01	
6.02	SETTLEMENT TO PROGRAM		356,229		0	6.02	
7.00	Total Medicare program liability (see instructions)		17,009,232		6,985,690	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: 140034  
Component CCN: 14S034

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2015 9:34 am

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		246,997		76,839	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		246,997		76,839	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		19,725		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		56	6.02
7.00	Total Medicare program liability (see instructions)		266,722		76,783	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: 140034

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
5/29/2015 9:34 am

		Title XVIII	Hospital	PPS
				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			4,050 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			10,365 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			773 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			15,947 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			241,610,771 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			4,168,334 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,375,311 8.00
9.00	Sequestration adjustment amount (see instructions)			27,506 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,347,805 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,421,281 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)			-73,476 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/29/2015 9:34 am
		Component CCN: 14S034	Title XVIII	Subprovider - IPF
		PPS		
		1.00		
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		336,352	1.00
2.00	Net IPF PPS Outlier Payments		906	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		5,761,644	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$ .		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		337,258	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		337,258	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		337,258	18.00
19.00	Deductibles		85,199	19.00
20.00	Subtotal (line 18 minus line 19)		252,059	20.00
21.00	Coinsurance		0	21.00
22.00	Subtotal (line 20 minus line 21)		252,059	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		30,933	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		20,106	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		24,000	25.00
26.00	Subtotal (sum of lines 22 and 24)		272,165	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		272,165	31.00
31.01	Sequestration adjustment (see instructions)		5,443	31.01
32.00	Interim payments		246,997	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		19,725	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		906	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet G Date/Time Prepared: 5/29/2015 9:34 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	-5,916,714	0	0	0	1.00
2.00	Temporary investments	-75,427	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,912,295	0	0	0	4.00
5.00	Other receivable	806,798	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,847,685	0	0	0	7.00
8.00	Prepaid expenses	215,786	0	0	0	8.00
9.00	Other current assets	2,681,250	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,471,673	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	1,259,000	0	0	0	12.00
13.00	Land improvements	667,527	0	0	0	13.00
14.00	Accumulated depreciation	-645,082	0	0	0	14.00
15.00	Buildings	27,639,835	0	0	0	15.00
16.00	Accumulated depreciation	-9,397,429	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,049,540	0	0	0	19.00
20.00	Accumulated depreciation	-787,417	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	18,994,126	0	0	0	23.00
24.00	Accumulated depreciation	-12,137,617	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)	27,642,483	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	2,427,630	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,427,630	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,541,786	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,790,881	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,866,741	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	3,624,091	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,281,713	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	2,450,000	0	0	0	46.00
47.00	Notes payable	39,568,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,602,065	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	49,620,065	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	57,901,778	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	-15,359,992	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)	-15,359,992	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,541,786	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140034

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

Worksheet G-1

Date/Time Prepared:  
5/29/2015 9:34 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		-10,307,413			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,794,966				2.00
3.00	Total (sum of line 1 and line 2)		-13,102,379			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFERS FROM OTHER FUNDS	-134,985		0		0	5.00
6.00	CORPORATE OFFICE	-11,656		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-146,641			0	10.00
11.00	Subtotal (line 3 plus line 10)		-13,249,020			0	11.00
12.00	DEDUCTION	-32,719		0		0	12.00
13.00	TRANSFER TO OTHER RELATED	3,847,763		0		0	13.00
14.00	TRANSFER DEBT	5,824		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,820,868			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-17,069,888			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFERS FROM OTHER FUNDS		0				5.00
6.00	CORPORATE OFFICE		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	DEDUCTION		0				12.00
13.00	TRANSFER TO OTHER RELATED		0				13.00
14.00	TRANSFER DEBT		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: 140034

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/29/2015 9:34 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	14,052,442		14,052,442	1.00
2.00	SUBPROVIDER - IPF	1,413,827		1,413,827	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	15,466,269		15,466,269	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,149,319		3,149,319	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,149,319		3,149,319	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,615,588		18,615,588	17.00
18.00	Ancillary services	64,406,028	137,261,178	201,667,206	18.00
19.00	Outpatient services	5,258,270	21,481,164	26,739,434	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
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)	88,279,886	158,742,342	247,022,228	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		85,896,290		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		85,896,290		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140034

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

Worksheet G-3

Date/Time Prepared:  
5/29/2015 9:34 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	247,022,228	1.00
2.00	Less contractual allowances and discounts on patients' accounts	169,461,149	2.00
3.00	Net patient revenues (line 1 minus line 2)	77,561,079	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	85,896,290	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,335,211	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	15,912	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	38	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	8,046	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	308,133	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	62,119	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	12,631	21.00
22.00	Rental of hospital space	199,693	22.00
23.00	Governmental appropriations	0	23.00
24.00	<b>OTHER REVENUE</b>	5,128,359	24.00
25.00	Total other income (sum of lines 6-24)	5,734,931	25.00
26.00	Total (line 5 plus line 25)	-2,600,280	26.00
27.00	<b>OTHER EXPENSES</b>	194,686	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	194,686	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,794,966	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140034	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/29/2015 9:34 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,233,358	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,808	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		44.67	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,236,166	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00