

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: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/29/2015 9:03 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2015 Time: 9:03 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 GOOD SAMARITAN REGIONAL HEALTH CTR. (140046) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	23,233	126,145	-17,095	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	28,218	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	51,451	126,145	-17,095	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 8:44 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1 GOOD SAMARITAN WAY			PO Box:						1.00	
2.00	City: MT. VERNON			State: IL		Zip Code: 62801		County: JEFFERSON		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		GOOD SAMARITAN REGIONAL HEALTH CTR.	140046	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		GOOD SAMARITAN REHABILITATION UNIT	14T046	99914	5	01/01/1990	N	P	P	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
17.20	Hospital-Based (OPT) I										17.20
17.30	Hospital-Based (OOT) I										17.30
17.40	Hospital-Based (OSP) I										17.40
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2014	12/31/2014				20.00
21.00	Type of Control (see instructions)					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	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.		5,106	1,123	0	4	0	239		24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 8:44 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.	130	18	0	0	0	25.00	
				Urban/Rural	S	Date of Geogr		
				1.00		2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.				2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				0		35.00	
				Beginning:	Ending:			
				1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.				0		37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.						38.00	
				Y/N	Y/N			
				1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				N	N	40.00	
				V	XVIII	XIX		
				1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)				N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.				N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.				N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.				N	N	N	48.00
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.				N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.				N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.				N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)				N			60.00
		Y/N	IME	Direct GME	IME	Direct GME		
		1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02	

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	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140046

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

Worksheet S-2
Part I
Date/Time Prepared:
5/29/2015 8:44 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
				1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00		
						1.00	2.00	3.00	
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.					N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)							0	71.00
Inpatient Rehabilitation Facility PPS									
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					Y			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)	N		0	76.00
		1.00			
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
		V		XIX	
		1.00		2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00
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
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical		Occupational	
		1.00		2.00	
		Speech		Respiratory	
		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			
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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.		2		118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,557,247	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		118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00	
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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		144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N		145.00	
				1.00	
				2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00	
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC				
161.10	CORF				
161.20	OUTPATIENT PHYSICAL THERAPY				
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 8:44 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: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/29/2015 8:44 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	
		Y/N	Date	Y/N	
		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: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/29/2015 8:44 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
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/12/2015		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	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR - GOVERNMENT 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: 140046

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2015 8:44 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	101	36,872	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)		101	36,872	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,840	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)		117	42,712	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	10	3,650		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
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)		127				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: 140046

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2015 8:44 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)	13,527	3,475	23,546			1.00
2.00 HMO and other (see instructions)	1,327	1,127				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	13,527	3,475	23,546			7.00
8.00 INTENSIVE CARE UNIT	1,767	483	3,129			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		1,148	1,888			13.00
14.00 Total (see instructions)	15,294	5,106	28,563	0.00	850.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	1,266	148	1,933	0.00	13.00	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	863.00	27.00
28.00 Observation Bed Days		0	2,165			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			352			30.00
31.00 Employee discount days - IRF			10			31.00
32.00 Labor & delivery days (see instructions)	0	239	383			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: 140046

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2015 8:44 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,330	1,310	6,728	1.00
2.00 HMO and other (see instructions)			279	0		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,330	1,310	6,728	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	132	10	188	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: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 8:44 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	46,316,503	0	46,316,503	1,795,358.00	25.80	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		50,626	0	50,626	284.73	177.80	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)		5,385,083	-207,548	5,177,535	100,816.00	51.36	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		948,095	0	948,095	16,879.98	56.17	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		728,042	0	728,042	5,203.50	139.91	13.00
14.00	Home office salaries & wage-related costs		9,116,311	0	9,116,311	195,764.93	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
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		23,703,349	0	23,703,349			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		3,118,497	0	3,118,497			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		6,731	0	6,731			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		249,993	0	249,993			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	210,490	207,548	418,038	0.00	0.00	26.00
27.00	Administrative & General	5.00	4,307,414	8,672	4,316,086	0.00	0.00	27.00
28.00	Administrative & General under contract (see inst.)		375,783	0	375,783	3,760.00	99.94	28.00
29.00	Maintenance & Repairs	6.00	869,193	-451,044	418,149	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	451,044	451,044	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	127,149	0	127,149	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,142,060	0	1,142,060	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	1,553,937	-1,013,870	540,067	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	1,013,870	1,013,870	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,012,295	0	1,012,295	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: 140046

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2015 8:44 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	Medical Records & Medical Records Library	16.00 801,122	0	801,122	0.00	0.00	41.00
42.00	Social Service	17.00 241,536	0	241,536	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140046

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2015 8:44 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	46,692,286	0	46,692,286	1,799,118.00	25.95	1.00
2.00	Excluded area salaries (see instructions)	5,385,083	-207,548	5,177,535	100,816.00	51.36	2.00
3.00	Subtotal salaries (line 1 minus line 2)	41,307,203	207,548	41,514,751	1,698,302.00	24.44	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,792,448	0	10,792,448	217,848.41	49.54	4.00
5.00	Subtotal wage-related costs (see inst.)	23,710,080	0	23,710,080	0.00	57.11	5.00
6.00	Total (sum of lines 3 thru 5)	75,809,731	207,548	76,017,279	1,916,150.41	39.67	6.00
7.00	Total overhead cost (see instructions)	10,640,979	216,220	10,857,199	3,760.00	2,887.55	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2015 8:44 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		230,068	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		4,465,695	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		13,326,929	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		258,963	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		105,817	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		7,273	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		130,528	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,555,783	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,561,638	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		70,151	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		176,063	22.00
23.00	Tuition Reimbursement		308,977	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		23,197,885	24.00
Part B - Other than Core Related Cost				
25.00	OTHER		36,942	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Prepared: 5/29/2015 8:44 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	948,095	0	1.00
2.00	Hospital	948,095	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			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: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/29/2015 8:44 am
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.342423	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		16,922,640	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		4,717,853	5.00
6.00	Medicaid charges		167,767,743	6.00
7.00	Medicaid cost (line 1 times line 6)		57,447,534	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)		35,807,041	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)		35,807,041	19.00
			1.00	
			1.00	
			2.00	
			3.00	
			4.00	
			5.00	
			6.00	
			7.00	
			8.00	
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			27.00	
			28.00	
			29.00	
			30.00	
			31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140046

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

Worksheet A
Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		7,840,307	7,840,307	8,086,046	15,926,353	1.00
2.00	00200		5,776,714	5,776,714	0	5,776,714	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	210,490	21,307,702	21,518,192	222,978	21,741,170	4.00
5.04	00570	0	3	3	0	3	5.04
5.05	00580	0	1,189	1,189	0	1,189	5.05
5.06	00590	4,307,414	26,399,431	30,706,845	-5,740,490	24,966,355	5.06
6.00	00600	869,193	2,366,423	3,235,616	-2,365,609	870,007	6.00
6.01	00601	0	1,298,898	1,298,898	0	1,298,898	6.01
7.00	00700	0	0	0	2,366,106	2,366,106	7.00
8.00	00800	127,149	446,035	573,184	0	573,184	8.00
9.00	00900	1,142,060	529,282	1,671,342	-140,498	1,530,844	9.00
10.00	01000	1,553,937	1,013,752	2,567,689	-1,724,134	843,555	10.00
11.00	01100	0	0	0	1,746,501	1,746,501	11.00
13.00	01300	1,012,295	45,534	1,057,829	0	1,057,829	13.00
16.00	01600	801,122	310,620	1,111,742	0	1,111,742	16.00
17.00	01700	241,536	11,184	252,720	0	252,720	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,036,018	1,408,535	11,444,553	-1,586,120	9,858,433	30.00
31.00	03100	2,395,256	518,649	2,913,905	722	2,914,627	31.00
41.00	04100	797,547	29,769	827,316	0	827,316	41.00
43.00	04300	0	0	0	1,007,637	1,007,637	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,559,893	9,582,479	13,142,372	97,954	13,240,326	50.00
52.00	05200	0	0	0	784,799	784,799	52.00
53.00	05300	0	948,913	948,913	0	948,913	53.00
54.00	05400	1,814,540	785,727	2,600,267	11,272	2,611,539	54.00
57.00	05700	323,847	113,645	437,492	892	438,384	57.00
58.00	05800	238,457	67,709	306,166	0	306,166	58.00
59.00	05900	828,033	2,268,379	3,096,412	139,055	3,235,467	59.00
60.00	06000	1,561,486	3,665,774	5,227,260	0	5,227,260	60.00
64.00	06400	194,595	42,759	237,354	86,577	323,931	64.00
65.00	06500	1,143,350	187,458	1,330,808	3,627	1,334,435	65.00
66.00	06600	1,018,915	23,681	1,042,596	0	1,042,596	66.00
67.00	06700	392,909	7,833	400,742	0	400,742	67.00
68.00	06800	232,672	9,112	241,784	0	241,784	68.00
69.00	06900	620,298	874,974	1,495,272	0	1,495,272	69.00
70.01	07001	65,281	37,136	102,417	0	102,417	70.01
71.00	07100	207,450	364,997	572,447	-572,447	0	71.00
73.00	07300	2,804,164	5,403,302	8,207,466	650	8,208,116	73.00
76.00	03950	16,251	645,121	661,372	0	661,372	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	169,567	65,182	234,749	80	234,829	90.00
90.01	09001	21,685	697	22,382	0	22,382	90.01
90.04	09005	94,486	288	94,774	0	94,774	90.04
90.05	09003	0	0	0	0	0	90.05
91.00	09100	2,927,071	1,475,293	4,402,364	21,332	4,423,696	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
118.00		41,728,967	95,874,486	137,603,453	2,446,930	140,050,383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	44,895	11,727	56,622	0	56,622	190.00
192.00	19200	3,950,972	3,169,328	7,120,300	-2,267,749	4,852,551	192.00
192.08	19208	0	0	0	0	0	192.08
193.06	19306	0	0	0	0	0	193.06
194.00	07950	315,591	45,830	361,421	-179,181	182,240	194.00
194.10	07951	276,078	878,685	1,154,763	0	1,154,763	194.10
194.20	07952	0	0	0	0	0	194.20
200.00		46,316,503	99,980,056	146,296,559	0	146,296,559	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140046

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

Worksheet A
Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-6,342,146	9,584,207	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,413,213	7,189,927	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,799,995	17,941,175	4.00
5.04	00570	ADMINISTRATIVE	0	3	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,189	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	10,142,529	35,108,884	5.06
6.00	00600	MAINTENANCE & REPAIRS	-59,012	810,995	6.00
6.01	00601	BIO MEDICAL SERVICES	-501,000	797,898	6.01
7.00	00700	OPERATION OF PLANT	0	2,366,106	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-3,210	569,974	8.00
9.00	00900	HOUSEKEEPING	-2,576	1,528,268	9.00
10.00	01000	DIETARY	-716,703	126,852	10.00
11.00	01100	CAFETERIA	-7,788	1,738,713	11.00
13.00	01300	NURSING ADMINISTRATION	-12,065	1,045,764	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,647	1,110,095	16.00
17.00	01700	SOCIAL SERVICE	-12,370	240,350	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-5,428	9,853,005	30.00
31.00	03100	INTENSIVE CARE UNIT	-12,491	2,902,136	31.00
41.00	04100	SUBPROVIDER - IIRF	-6,997	820,319	41.00
43.00	04300	NURSERY	0	1,007,637	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-451	13,239,875	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	784,799	52.00
53.00	05300	ANESTHESIOLOGY	-596,439	352,474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-10,148	2,601,391	54.00
57.00	05700	CT SCAN	0	438,384	57.00
58.00	05800	MRI	0	306,166	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,235,467	59.00
60.00	06000	LABORATORY	-229,308	4,997,952	60.00
64.00	06400	INTRAVENOUS THERAPY	0	323,931	64.00
65.00	06500	RESPIRATORY THERAPY	-12,621	1,321,814	65.00
66.00	06600	PHYSICAL THERAPY	-135	1,042,461	66.00
67.00	06700	OCCUPATIONAL THERAPY	-37	400,705	67.00
68.00	06800	SPEECH PATHOLOGY	-5,076	236,708	68.00
69.00	06900	ELECTROCARDIOLOGY	-691,346	803,926	69.00
70.01	07001	NEUROLOGY	-20,467	81,950	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-115,643	8,092,473	73.00
76.00	03950	ACUTE DIALYSIS	-8,876	652,496	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	234,829	90.00
90.01	09001	DIABETES EDUCATION	0	22,382	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	94,774	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	90.05
91.00	09100	EMERGENCY	-1,119,697	3,303,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS					
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
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,737,930	137,312,453	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	56,622	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	4,852,551	192.00
192.08	19208	FOUNDATION	0	0	192.08
193.06	19306	OUTSIDE ACCOUNTING	0	0	193.06
194.00	07950	CHILD CARE	0	182,240	194.00
194.10	07951	RETAIL PHARMACY	0	1,154,763	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	0	194.20
200.00		TOTAL (SUM OF LINES 118-199)	-2,737,930	143,558,629	200.00

RECLASSIFICATIONS

Provider CCN: 140046

Period:
From 01/01/2014
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		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - OBSTETRICS UNIT COST						
1.00	NURSERY	43.00	852,001	155,636	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	635,431	116,075	2.00	
	O		1,487,432	271,711		
B - PLANT OPERATIONS						
1.00	OPERATION OF PLANT	7.00	451,044	1,915,062	1.00	
	O		451,044	1,915,062		
C - MATERIALS MANAGEMENT						
1.00		0.00	0	0	1.00	
2.00	OPERATING ROOM	50.00	76,995	20,959	2.00	
3.00	DELIVERY ROOM & LABOR ROOM	52.00	6	2	3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	8,860	2,412	4.00	
5.00	CT SCAN	57.00	701	191	5.00	
6.00	CARDIAC CATHETERIZATION	59.00	109,302	29,753	6.00	
7.00	RESPIRATORY THERAPY	65.00	2,851	776	7.00	
8.00	CLINIC	90.00	63	17	8.00	
	O		198,778	54,110		
D - RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,550,011	1.00	
2.00		0.00	0	0	2.00	
	O		0	7,550,011		
E - SHARED DIETARY COST						
1.00	CAFETERIA	11.00	1,013,870	732,631	1.00	
	O		1,013,870	732,631		
F - MAILROOM COST						
1.00	ADMINISTRATIVE & GENERAL	5.06	8,672	0	1.00	
	O		8,672	0		
G - CHILD CARE DIETARY						
1.00	DIETARY	10.00	0	22,367	1.00	
	O		0	22,367		
H - EMPLOYEE CHILD CARE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	207,548	15,430	1.00	
	O		207,548	15,430		
I - IV PUMP EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	173,023	1.00	
2.00	INTENSIVE CARE UNIT	31.00	0	722	2.00	
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	33,285	3.00	
4.00	INTRAVENOUS THERAPY	64.00	0	86,577	4.00	
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	650	5.00	
6.00	EMERGENCY	91.00	0	21,332	6.00	
	O		0	315,589		
J - INVENTORY COST						
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	4,702	1.00	
	O		0	4,702		
K - DOCUMENT SHREDDING COST						
1.00	ADMINISTRATIVE & GENERAL	5.06	0	140,498	1.00	
	O		0	140,498		
L - MEDICAL PLAZA EXPENSES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	602,199	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.06	0	447,604	2.00	
3.00	MAINTENANCE & REPAIRS	6.00	0	497	3.00	
	TOTALS		0	1,050,300		
M - CHILD CARE DEPRECIATION						
1.00	CHILD CARE	194.00	0	66,164	1.00	
	TOTALS		0	66,164		
500.00	Grand Total: Increases		3,367,344	12,138,575	500.00	

RECLASSIFICATIONS

Provider CCN: 140046

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

Worksheet A-6
Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - OBSTETRICS UNIT COST							
1.00	ADULTS & PEDIATRICS	30.00	852,001	155,636	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	635,431	116,075	0		2.00
	O		1,487,432	271,711			
B - PLANT OPERATIONS							
1.00	MAINTENANCE & REPAIRS	6.00	451,044	1,915,062	0		1.00
	O		451,044	1,915,062			
C - MATERIALS MANAGEMENT							
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	198,778	54,110	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
	O		198,778	54,110			
D - RECLASS INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.06	0	6,332,562	11		1.00
2.00	PHYSICIANS PRIVATE OFFICES	192.00	0	1,217,449	0		2.00
	O		0	7,550,011			
E - SHARED DIETARY COST							
1.00	DIETARY	10.00	1,013,870	732,631	0		1.00
	O		1,013,870	732,631			
F - MAILROOM COST							
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	8,672	0	0		1.00
	O		8,672	0			
G - CHILD CARE DIETARY							
1.00	CHILD CARE	194.00	0	22,367	0		1.00
	O		0	22,367			
H - EMPLOYEE CHILD CARE							
1.00	CHILD CARE	194.00	207,548	15,430	0		1.00
	O		207,548	15,430			
I - IV PUMP EXPENSE							
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	315,589	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
	O		0	315,589			
J - INVENTORY COST							
1.00	ADMINISTRATIVE & GENERAL	5.06	0	4,702	0		1.00
	O		0	4,702			
K - DOCUMENT SHREDDING COST							
1.00	HOUSEKEEPING	9.00	0	140,498	0		1.00
	O		0	140,498			
L - MEDICAL PLAZA EXPENSES							
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	1,050,300	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	1,050,300			
M - CHILD CARE DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66,164	9		1.00
	TOTALS		0	66,164			
500.00	Grand Total: Decreases		3,367,344	12,138,575			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140046

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

Worksheet A-7
Part I
Date/Time Prepared:
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	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	627,759	5,000	0	5,000	0	1.00
2.00	Land Improvements	6,501,399	0	0	0	0	2.00
3.00	Buildings and Fixtures	155,059,281	527,849	0	527,849	60,075	3.00
4.00	Building Improvements	17,704,618	833,516	0	833,516	0	4.00
5.00	Fixed Equipment	13,607,338	43,703	0	43,703	2,903	5.00
6.00	Movable Equipment	56,391,578	1,268,897	0	1,268,897	802,774	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	249,891,973	2,678,965	0	2,678,965	865,752	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	249,891,973	2,678,965	0	2,678,965	865,752	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	632,759	0				1.00
2.00	Land Improvements	6,501,399	0				2.00
3.00	Buildings and Fixtures	155,527,055	0				3.00
4.00	Building Improvements	18,538,134	0				4.00
5.00	Fixed Equipment	13,648,138	0				5.00
6.00	Movable Equipment	56,857,701	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	251,705,186	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	251,705,186	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140046

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	7,840,307	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,776,714	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,617,021	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	7,840,307				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,776,714				2.00
3.00	Total (sum of lines 1-2)	0	13,617,021				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prepared: 5/29/2015 8:44 am
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	8,579,853	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,189,927	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,769,780	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	1,004,354	0	0	0	9,584,207	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	7,189,927	2.00
3.00	Total (sum of lines 1-2)	1,004,354	0	0	0	16,774,134	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140046

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

Worksheet A-8

Date/Time Prepared:
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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			
			Cost Center		Line #	Wkst. A-7 Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-4,424	CAP REL COSTS-BLDG & FIXT	1.00	11	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)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,825,219			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-5,538	RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,706,584			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-716,559	DIETARY	10.00	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	B	-34,321	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-1,647	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-7,788	CAFETERIA	11.00	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	B	-14,734	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	B	195,111	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00		0		0.00	0	33.00
33.02 MANAGEMENT FEES	B	-683,968	ADMINISTRATIVE & GENERAL	5.06	0	33.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 140046

Period:
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Worksheet A-8

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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				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
34.00		0			0.00	0	34.00
35.00		0			0.00	0	35.00
36.00	RENT REVENUE	B	-58,867	MAINTENANCE & REPAIRS	6.00	0	36.00
36.50			0		0.00	0	36.50
37.00	LAUNDRY REVENUE	B	-3,210	LAUNDRY & LINEN SERVICE	8.00	0	37.00
38.00	VENDING COMMISSIONS AND RECYCLI	B	-2,296	HOUSEKEEPING	9.00	0	38.00
39.00	SOCIAL SERVICES REVENUE	B	-12,345	SOCIAL SERVICE	17.00	0	39.00
40.00	A&P REVENUE	B	-1,121	ADULTS & PEDIATRICS	30.00	0	40.00
40.05			0		0.00	0	40.05
41.00			0		0.00	0	41.00
41.01	CARDIAC EXERCISE	B	-10,148	ELECTROCARDIOLOGY	69.00	0	41.01
41.20			0		0.00	0	41.20
41.40			0		0.00	0	41.40
42.00	MANAGEMENT FEE	B	-13,458	NEUROLOGY	70.01	0	42.00
44.00			0		0.00	0	44.00
45.00	RENTAL INCOME	B	458	ADMINISTRATIVE & GENERAL	5.06	0	45.00
45.01	NON-PATIENT TELEPHONE COST	A	-30,562	ADMINISTRATIVE & GENERAL	5.06	0	45.01
45.02	NON-PATIENT TELEPHONE DEPR	A	-6,815	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.02
45.03	EMPLOYEE CHILD CARE	A	-201,981	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	REAL ESTATE TAXES	A	-1,391	ADMINISTRATIVE & GENERAL	5.06	0	45.04
45.05	ADVERTISING	A	-21,722	ADMINISTRATIVE & GENERAL	5.06	0	45.05
45.06	PHYSICIAN RECRUITMENT	A	-367,631	ADMINISTRATIVE & GENERAL	5.06	0	45.06
45.07			0		0.00	0	45.07
45.08	LOBBYING DUES	A	-35,508	ADMINISTRATIVE & GENERAL	5.06	0	45.08
45.09	MGMT - CLAY	A	-314,913	ADMINISTRATIVE & GENERAL	5.06	0	45.09
45.10	GIFTS & ENTERTAINMENT	A	-145	MAINTENANCE & REPAIRS	6.00	0	45.10
45.11	GIFTS & ENTERTAINMENT	A	-25,891	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.11
45.12	GIFTS & ENTERTAINMENT	A	-170,904	ADMINISTRATIVE & GENERAL	5.06	0	45.12
45.13	NON-PATIENT TELEPHONE (SALARY)	A	-26,407	ADMINISTRATIVE & GENERAL	5.06	0	45.13
45.14	NON-PATIENT TELEPHONE (BENEFITS	A	-12,268	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.14
45.15	GIFTS & ENTERTAINMENT	A	-280	HOUSEKEEPING	9.00	0	45.15
45.16	PERSONAL USE (AUTO)	A	-2,448	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.16
45.17	GIFTS & ENTERTAINMENT	A	-144	DIETARY	10.00	0	45.17
45.18	GIFTS & ENTERTAINMENT	A	-65	NURSING ADMINISTRATION	13.00	0	45.18
45.19	GIFTS & ENTERTAINMENT	A	-25	SOCIAL SERVICE	17.00	0	45.19
45.20	PERSONAL USE (DUES)	A	-750	ADMINISTRATIVE & GENERAL	5.06	0	45.20
45.21	GIFTS & ENTERTAINMENT	A	-2,234	ADULTS & PEDIATRICS	30.00	0	45.21
45.22	GIFTS & ENTERTAINMENT	A	-73	INTENSIVE CARE UNIT	31.00	0	45.22
45.23	GIFTS & ENTERTAINMENT	A	-451	OPERATING ROOM	50.00	0	45.23
45.24	GIFTS & ENTERTAINMENT	A	-95	LABORATORY	60.00	0	45.24
45.25	GIFTS & ENTERTAINMENT	A	-135	PHYSICAL THERAPY	66.00	0	45.25
45.26	ADVERTISING (A&P)	A	-2,073	ADULTS & PEDIATRICS	30.00	0	45.26
45.27	GIFTS & ENTERTAINMENT	A	-37	OCCUPATIONAL THERAPY	67.00	0	45.27
45.28			0		0.00	0	45.28
45.29	ADVERTISING (SUB)	A	-1,314	SUBPROVIDER - I RF	41.00	0	45.29
45.30	MD RECRUITMENT	A	-12,000	NURSING ADMINISTRATION	13.00	0	45.30
45.31	GIFTS & ENTERTAINMENT	A	-76	SPEECH PATHOLOGY	68.00	0	45.31
45.32	GIFTS & ENTERTAINMENT	A	-153	DRUGS CHARGED TO PATIENTS	73.00	0	45.32
45.33	GIFTS & ENTERTAINMENT	A	-949	EMERGENCY	91.00	0	45.33
45.34			0		0.00	0	45.34
45.35			0		0.00	0	45.35
45.36	MD RECRUITMENT	A	-5,000	SPEECH PATHOLOGY	68.00	0	45.36
45.75			0		0.00	0	45.75
46.00			0		0.00	0	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,737,930				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: 140046

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2015 8:44 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	218,245	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	1,227,365	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE - INTEREST	912,233	7,453,466
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	13,882,817	17,442,672
4.01	5.06	ADMINISTRATIVE & GENERAL	HOME OFFICE	11,944,231	0
4.02	6.01	BIOMEDICAL SERVICES	HOME OFFICE	0	501,000
4.03	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	-81,169	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			28,103,722	25,397,138

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

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

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

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

6.00	B		0.00	SSM	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				0.00	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.

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

Provider CCN: 140046

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2015 8:44 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	218,245	9		1.00
2.00	1,227,365	9		2.00
3.00	-6,541,233	11		3.00
4.00	-3,559,855	0		4.00
4.01	11,944,231	0		4.01
4.02	-501,000	0		4.02
4.03	-81,169	0		4.03
5.00	2,706,584			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140046

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2015 8:44 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	5.06	ADMINISTRATIVE & GENERAL	316,655	-3,025	319,680	159,800	2,190	1.00
2.00	31.00	INTENSIVE CARE UNIT	21,484	0	21,484	159,800	118	2.00
3.00	41.00	SUBPROVIDER - IRF	52,932	0	52,932	159,800	615	3.00
4.00	53.00	ANESTHESIOLOGY	633,160	550,000	83,160	167,500	456	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	16,850	-6,500	23,350	217,600	117	5.00
6.00	60.00	LABORATORY	256,213	182,190	74,023	208,000	270	6.00
7.00	65.00	RESPIRATORY THERAPY	18,076	5,185	12,891	159,800	71	7.00
8.00	69.00	ELECTROCARDIOLOGY	843,380	627,170	216,210	159,800	2,111	8.00
9.00	70.01	NEUROLOGY	11,619	0	11,619	159,800	60	9.00
10.00	76.00	ACUTE DIALYSIS	16,251	0	16,251	159,800	96	10.00
11.00	91.00	EMERGENCY	1,118,748	1,118,748	0	159,800	0	11.00
200.00			3,305,368	2,473,768	831,600		6,104	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	5.06	ADMINISTRATIVE & GENERAL	168,251	8,413	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	9,066	453	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	47,249	2,362	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	36,721	1,836	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	12,240	612	0	0	0	5.00
6.00	60.00	LABORATORY	27,000	1,350	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	5,455	273	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	162,182	8,109	0	0	0	8.00
9.00	70.01	NEUROLOGY	4,610	231	0	0	0	9.00
10.00	76.00	ACUTE DIALYSIS	7,375	369	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			480,149	24,008	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	5.06	ADMINISTRATIVE & GENERAL	0	168,251	151,429	148,404		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	9,066	12,418	12,418		2.00
3.00	41.00	SUBPROVIDER - IRF	0	47,249	5,683	5,683		3.00
4.00	53.00	ANESTHESIOLOGY	0	36,721	46,439	596,439		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	12,240	11,110	4,610		5.00
6.00	60.00	LABORATORY	0	27,000	47,023	229,213		6.00
7.00	65.00	RESPIRATORY THERAPY	0	5,455	7,436	12,621		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	162,182	54,028	681,198		8.00
9.00	70.01	NEUROLOGY	0	4,610	7,009	7,009		9.00
10.00	76.00	ACUTE DIALYSIS	0	7,375	8,876	8,876		10.00
11.00	91.00	EMERGENCY	0	0	0	1,118,748		11.00
200.00			0	480,149	351,451	2,825,219		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.04	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	9,584,207	9,584,207			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	7,189,927		7,189,927		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	17,941,175	235,997	0	18,177,172	4.00
5.04 00570	ADMITTING	3	55,285	0	0	55,288 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,189	0	2,602	0	0 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	35,108,884	1,203,446	1,587,714	1,848,148	42 5.06
6.00 00600	MAINTENANCE & REPAIRS	810,995	1,122,591	0	178,926	0 6.00
6.01 00601	BIO MEDICAL SERVICES	797,898	6,471	4,623	0	0 6.01
7.00 00700	OPERATION OF PLANT	2,366,106	365,738	681,847	193,002	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	569,974	103,056	1,408	54,407	0 8.00
9.00 00900	HOUSEKEEPING	1,528,268	240,311	42,594	488,687	0 9.00
10.00 01000	DIETARY	126,852	92,780	4,730	231,095	4 10.00
11.00 01100	CAFETERIA	1,738,713	242,347	12,359	433,835	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,045,764	45,978	414,393	433,161	0 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,110,095	98,257	3,891	342,800	0 16.00
17.00 01700	SOCIAL SERVICE	240,350	84,442	0	103,353	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,853,005	1,358,541	87,300	3,657,944	2,964 30.00
31.00 03100	INTENSIVE CARE UNIT	2,902,136	424,465	157,930	1,024,930	711 31.00
41.00 04100	SUBPROVIDER - IRF	820,319	218,813	0	341,270	189 41.00
43.00 04300	NURSERY	1,007,637	25,958	42,711	364,571	317 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	13,239,875	761,627	927,527	1,556,224	10,516 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	784,799	234,131	31,856	271,903	1,444 52.00
53.00 05300	ANESTHESIOLOGY	352,474	6,205	66,246	0	1,313 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,601,391	542,693	925,242	783,014	4,652 54.00
57.00 05700	CT SCAN	438,384	93,483	185,359	138,874	5,611 57.00
58.00 05800	MRI	306,166	52,619	47,190	102,036	1,459 58.00
59.00 05900	CARDIAC CATHETERIZATION	3,235,467	159,601	77,849	401,086	4,493 59.00
60.00 06000	LABORATORY	4,997,952	215,347	268,901	668,160	7,835 60.00
64.00 06400	INTRAVENOUS THERAPY	323,931	32,817	1,675	83,267	191 64.00
65.00 06500	RESPIRATORY THERAPY	1,321,814	35,677	63,256	490,459	1,512 65.00
66.00 06600	PHYSICAL THERAPY	1,042,461	90,647	10,520	435,994	883 66.00
67.00 06700	OCCUPATIONAL THERAPY	400,705	83,448	873	168,126	318 67.00
68.00 06800	SPEECH PATHOLOGY	236,708	16,505	2,576	99,560	94 68.00
69.00 06900	ELECTROCARDIOLOGY	803,926	424,634	107,118	261,360	1,693 69.00
70.01 07001	NEUROLOGY	81,950	31,484	19,146	27,934	58 70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	8,092,473	81,873	59,848	1,199,902	5,572 73.00
76.00 03950	ACUTE DIALYSIS	652,496	25,691	8,143	6,954	172 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	234,829	52,401	6,280	72,585	102 90.00
90.01 09001	DIABETES EDUCATION	22,382	0	0	9,279	3 90.01
90.04 09005	ANTI COAGULATION CLINIC	94,774	24,552	0	40,431	63 90.04
90.05 09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0 90.05
91.00 09100	EMERGENCY	3,303,999	377,711	106,733	1,251,477	3,077 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS						
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
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	137,312,453	9,267,622	5,960,440	17,764,754	55,288 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	56,622	34,489	1,520	19,211	0 190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	4,852,551	0	1,205,145	228,841	0 192.00
192.08 19208	FOUNDATION	0	8,750	0	0	0 192.08
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	0 193.06
194.00 07950	CHILD CARE	182,240	241,159	1,862	46,232	0 194.00
194.10 07951	RETAIL PHARMACY	1,154,763	32,187	20,960	118,134	0 194.10
194.20 07952	OTHER NON-REIMBURSABLE	0	0	0	0	0 194.20
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	143,558,629	9,584,207	7,189,927	18,177,172	55,288 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	BIOMEDICAL SERVICES	
			5.05	5A.05	5.06	6.00	6.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00570	ADMINISTRATIVE						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,791					5.05
5.06	00590	ADMINISTRATIVE & GENERAL	3	39,748,237	39,748,237			5.06
6.00	00600	MAINTENANCE & REPAIRS	0	2,112,512	808,866	2,921,378		6.00
6.01	00601	BIOMEDICAL SERVICES	0	808,992	309,757	1,444	1,120,193	6.01
7.00	00700	OPERATION OF PLANT	0	3,606,693	1,380,978	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	728,845	279,070	25,023	0	8.00
9.00	00900	HOUSEKEEPING	0	2,299,860	880,600	75,549	0	9.00
10.00	01000	DIETARY	0	455,461	174,393	97,684	0	10.00
11.00	01100	CAFETERIA	0	2,427,254	929,379	255,518	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,939,296	742,543	1,444	30,446	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,555,043	595,415	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	428,145	163,934	481	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	204	14,959,958	5,728,063	793,020	81,391	30.00
31.00	03100	INTENSIVE CARE UNIT	49	4,510,221	1,726,932	160,240	21,515	31.00
41.00	04100	SUBPROVIDER - I RF	13	1,380,604	528,624	41,865	0	41.00
43.00	04300	NURSERY	22	1,441,216	551,832	72,662	18,876	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	700	16,496,469	6,316,345	228,571	247,421	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	100	1,324,233	507,040	54,376	14,208	52.00
53.00	05300	ANESTHESIOLOGY	91	426,329	163,238	0	82,812	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325	4,857,317	1,859,833	31,759	195,663	54.00
57.00	05700	CT SCAN	387	862,098	330,091	5,293	4,059	57.00
58.00	05800	MRI	101	509,571	195,111	2,406	28,213	58.00
59.00	05900	CARDIAC CATHETERIZATION	310	3,878,806	1,485,168	68,331	182,876	59.00
60.00	06000	LABORATORY	540	6,158,735	2,358,137	12,030	35,520	60.00
64.00	06400	INTRAVENOUS THERAPY	13	441,894	169,198	34,165	0	64.00
65.00	06500	RESPIRATORY THERAPY	104	1,912,822	732,406	12,992	46,683	65.00
66.00	06600	PHYSICAL THERAPY	61	1,580,566	605,188	0	9,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	22	653,492	250,218	0	5,074	67.00
68.00	06800	SPEECH PATHOLOGY	6	355,449	136,099	0	203	68.00
69.00	06900	ELECTROCARDIOLOGY	117	1,598,848	612,188	113,564	76,926	69.00
70.01	07001	NEUROLOGY	4	160,576	61,483	0	3,856	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	384	9,440,052	3,614,530	89,985	13,396	73.00
76.00	03950	ACUTE DIALYSIS	12	693,468	265,524	13,474	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7	366,204	140,217	0	203	90.00
90.01	09001	DIABETES EDUCATION	0	31,664	12,124	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	4	159,824	61,195	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	212	5,043,209	1,931,009	216,541	21,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)		0				92.00
OTHER REIMBURSABLE COST CENTERS								
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
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,791	135,353,963	36,606,728	2,408,417	1,120,193	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	111,842	42,824	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6,286,537	2,407,071	501,413	0	192.00
192.08	19208	FOUNDATION	0	8,750	3,350	962	0	192.08
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
194.00	07950	CHILD CARE	0	471,493	180,531	10,586	0	194.00
194.10	07951	RETAIL PHARMACY	0	1,326,044	507,733	0	0	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.20
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)	3,791	143,558,629	39,748,237	2,921,378	1,120,193	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

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Part I
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	BIOMEDICAL SERVICES					6.01
7.00	00700	OPERATION OF PLANT	4,987,671				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,943	1,110,881			8.00
9.00	00900	HOUSEKEEPING	181,751	5,555	3,443,315		9.00
10.00	01000	DIETARY	70,171	2,153	51,104	850,966	10.00
11.00	01100	CAFETERIA	183,291	5,624	133,488	0	3,934,554
13.00	01300	NURSING ADMINISTRATION	34,774	0	25,325	0	88,483
16.00	01600	MEDICAL RECORDS & LIBRARY	74,314	0	54,122	0	123,877
17.00	01700	SOCIAL SERVICE	63,865	0	46,512	0	29,494
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,027,487	521,669	748,304	617,299	1,055,898
31.00	03100	INTENSIVE CARE UNIT	321,030	107,422	233,801	38,432	230,056
41.00	04100	SUBPROVIDER - IIRF	165,492	55,544	120,525	32,423	76,685
43.00	04300	NURSERY	19,632	16,664	14,298	0	88,483
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	576,032	92,536	419,516	26,631	383,427
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,077	0	128,963	0	64,888
53.00	05300	ANESTHESIOLOGY	4,693	0	3,418	0	200,562
54.00	05400	RADIOLOGY-DIAGNOSTIC	410,449	101,201	298,924	0	0
57.00	05700	CT SCAN	70,703	0	51,492	0	35,393
58.00	05800	MRI	39,797	22,217	28,983	0	23,596
59.00	05900	CARDIAC CATHETERIZATION	120,709	11,109	87,911	0	106,180
60.00	06000	LABORATORY	162,871	0	118,616	0	230,056
64.00	06400	INTRAVENOUS THERAPY	24,820	0	18,076	0	17,697
65.00	06500	RESPIRATORY THERAPY	26,983	0	19,651	0	147,472
66.00	06600	PHYSICAL THERAPY	68,558	0	49,930	0	112,079
67.00	06700	OCCUPATIONAL THERAPY	63,113	0	45,965	0	35,393
68.00	06800	SPEECH PATHOLOGY	12,483	0	9,091	0	23,596
69.00	06900	ELECTROCARDIOLOGY	321,158	5,555	233,895	0	76,685
70.01	07001	NEUROLOGY	23,812	2,777	17,342	0	5,899
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	61,922	35,882	45,097	0	265,450
76.00	03950	ACUTE DIALYSIS	19,431	2,443	14,151	0	5,899
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	39,632	0	28,863	0	17,697
90.01	09001	DIABETES EDUCATION	0	0	0	0	5,899
90.04	09005	ANTI COAGULATION CLINIC	18,569	0	13,524	0	5,899
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0
91.00	09100	EMERGENCY	285,670	114,754	208,049	12,378	306,742
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,748,232	1,103,105	3,268,936	727,163	3,763,485
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	26,085	0	18,997	0	11,798
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	112,079
192.08	19208	FOUNDATION	6,617	0	4,819	0	0
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0
194.00	07950	CHILD CARE	182,393	7,776	132,834	123,803	23,596
194.10	07951	RETAIL PHARMACY	24,344	0	17,729	0	23,596
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,987,671	1,110,881	3,443,315	850,966	3,934,554

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

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

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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
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						10.00
11.00	01100						11.00
13.00	01300	2,862,311					13.00
16.00	01600	90,932	2,493,703				16.00
17.00	01700	24,201	0	756,632			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	787,464	134,196	620,438	27,075,187	0	30.00
31.00	03100	173,141	32,188	0	7,554,978	0	31.00
41.00	04100	55,938	8,545	0	2,466,245	0	41.00
43.00	04300	66,293	14,359	0	2,304,315	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	287,178	468,966	0	25,543,092	0	50.00
52.00	05200	49,445	65,387	0	2,385,617	0	52.00
53.00	05300	0	59,439	0	940,491	0	53.00
54.00	05400	148,819	210,591	0	8,114,556	0	54.00
57.00	05700	26,493	253,997	0	1,639,619	0	57.00
58.00	05800	16,787	66,052	0	932,733	0	58.00
59.00	05900	78,939	203,386	0	6,223,415	0	59.00
60.00	06000	170,508	354,703	0	9,601,176	0	60.00
64.00	06400	13,386	8,662	0	727,898	0	64.00
65.00	06500	109,765	68,466	0	3,077,240	0	65.00
66.00	06600	82,132	39,980	0	2,547,973	0	66.00
67.00	06700	25,825	14,389	0	1,093,469	0	67.00
68.00	06800	16,208	4,240	0	557,369	0	68.00
69.00	06900	56,803	76,649	0	3,172,271	0	69.00
70.01	07001	5,898	2,623	0	284,266	0	70.01
71.00	07100	0	0	0	0	0	71.00
73.00	07300	197,477	252,220	0	14,016,011	0	73.00
76.00	03950	102	7,792	0	1,022,284	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	15,127	4,597	0	612,540	0	90.00
90.01	09001	2,203	118	0	52,008	0	90.01
90.04	09005	5,078	2,862	0	266,951	0	90.04
90.05	09003	0	0	0	0	0	90.05
91.00	09100	230,747	139,296	136,194	8,645,901	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
118.00		2,736,889	2,493,703	756,632	130,857,605	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	9,163	0	0	220,709	0	190.00
192.00	19200	83,862	0	0	9,390,962	0	192.00
192.08	19208	0	0	0	24,498	0	192.08
193.06	19306	0	0	0	0	0	193.06
194.00	07950	16,855	0	0	1,149,867	0	194.00
194.10	07951	15,542	0	0	1,914,988	0	194.10
194.20	07952	0	0	0	0	0	194.20
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		2,862,311	2,493,703	756,632	143,558,629	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

Period:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.04	00570 ADMI TTING		5.04
5.05	00580 CASHI ERING/ACCOUNTS RECEI VABLE		5.05
5.06	00590 ADMI NI STRATI VE & GENERAL		5.06
6.00	00600 MAINTENANCE & REPAIRS		6.00
6.01	00601 BIOMEDI CAL SERVI CES		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 DI ETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON		13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY		16.00
17.00	01700 SOCI AL SERVI CE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	27,075,187	30.00
31.00	03100 INTENSIVE CARE UNIT	7,554,978	31.00
41.00	04100 SUBPROVIDER - IRF	2,466,245	41.00
43.00	04300 NURSERY	2,304,315	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	25,543,092	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,385,617	52.00
53.00	05300 ANESTHESIOLOGY	940,491	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,114,556	54.00
57.00	05700 CT SCAN	1,639,619	57.00
58.00	05800 MRI	932,733	58.00
59.00	05900 CARDIAC CATHETERIZATION	6,223,415	59.00
60.00	06000 LABORATORY	9,601,176	60.00
64.00	06400 INTRAVENOUS THERAPY	727,898	64.00
65.00	06500 RESPIRATORY THERAPY	3,077,240	65.00
66.00	06600 PHYSICAL THERAPY	2,547,973	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,093,469	67.00
68.00	06800 SPEECH PATHOLOGY	557,369	68.00
69.00	06900 ELECTROCARDIOLOGY	3,172,271	69.00
70.01	07001 NEUROLOGY	284,266	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,016,011	73.00
76.00	03950 ACUTE DIALYSIS	1,022,284	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	612,540	90.00
90.01	09001 DIABETES EDUCATION	52,008	90.01
90.04	09005 ANTI COAGULATION CLINIC	266,951	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	90.05
91.00	09100 EMERGENCY	8,645,901	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	130,857,605	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	220,709	190.00
192.00	19200 PHYSICIANS PRIVATE OFFICES	9,390,962	192.00
192.08	19208 FOUNDATION	24,498	192.08
193.06	19306 OUTSIDE ACCOUNTING	0	193.06
194.00	07950 CHILD CARE	1,149,867	194.00
194.10	07951 RETAIL PHARMACY	1,914,988	194.10
194.20	07952 OTHER NON-REIMBURSABLE	0	194.20
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	143,558,629	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140046

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	235,997	0	235,997	4.00
5.04 00570	ADMINISTRATIVE	0	55,285	0	55,285	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	2,602	2,602	5.05
5.06 00590	ADMINISTRATIVE & GENERAL	457,033	1,203,446	1,587,714	3,248,193	5.06
6.00 00600	MAINTENANCE & REPAIRS	0	1,122,591	0	1,122,591	6.00
6.01 00601	BIOMEDICAL SERVICES	0	6,471	4,623	11,094	6.01
7.00 00700	OPERATION OF PLANT	47,345	365,738	681,847	1,094,930	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	103,056	1,408	104,464	8.00
9.00 00900	HOUSEKEEPING	0	240,311	42,594	282,905	9.00
10.00 01000	DIETARY	0	92,780	4,730	97,510	10.00
11.00 01100	CAFETERIA	0	242,347	12,359	254,706	11.00
13.00 01300	NURSING ADMINISTRATION	0	45,978	414,393	460,371	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	98,257	3,891	102,148	16.00
17.00 01700	SOCIAL SERVICE	0	84,442	0	84,442	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	251,494	1,358,541	87,300	1,697,335	30.00
31.00 03100	INTENSIVE CARE UNIT	10,441	424,465	157,930	592,836	31.00
41.00 04100	SUBPROVIDER - IRF	0	218,813	0	218,813	41.00
43.00 04300	NURSERY	0	25,958	42,711	68,669	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	52,948	761,627	927,527	1,742,102	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	33,286	234,131	31,856	299,273	52.00
53.00 05300	ANESTHESIOLOGY	4,760	6,205	66,246	77,211	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	44,893	542,693	925,242	1,512,828	54.00
57.00 05700	CT SCAN	92	93,483	185,359	278,934	57.00
58.00 05800	MRI	0	52,619	47,190	99,809	58.00
59.00 05900	CARDIAC CATHETERIZATION	49,822	159,601	77,849	287,272	59.00
60.00 06000	LABORATORY	728	215,347	268,901	484,976	60.00
64.00 06400	INTRAVENOUS THERAPY	86,577	32,817	1,675	121,069	64.00
65.00 06500	RESPIRATORY THERAPY	20,994	35,677	63,256	119,927	65.00
66.00 06600	PHYSICAL THERAPY	1,140	90,647	10,520	102,307	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	83,448	873	84,321	67.00
68.00 06800	SPEECH PATHOLOGY	0	16,505	2,576	19,081	68.00
69.00 06900	ELECTROCARDIOLOGY	134	424,634	107,118	531,886	69.00
70.01 07001	NEUROLOGY	23,339	31,484	19,146	73,969	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	218,535	81,873	59,848	360,256	73.00
76.00 03950	ACUTE DIALYSIS	0	25,691	8,143	33,834	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	56	52,401	6,280	58,737	90.00
90.01 09001	DIABETES EDUCATION	0	0	0	0	90.01
90.04 09005	ANTI COAGULATION CLINIC	0	24,552	0	24,552	90.04
90.05 09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	90.05
91.00 09100	EMERGENCY	21,332	377,711	106,733	505,776	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
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
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,324,949	9,267,622	5,960,440	16,553,011	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	34,489	1,520	36,009	190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	590,981	0	1,205,145	1,796,126	192.00
192.08 19208	FOUNDATION	4,587	8,750	0	13,337	192.08
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	193.06
194.00 07950	CHILD CARE	0	241,159	1,862	243,021	194.00
194.10 07951	RETAIL PHARMACY	0	32,187	20,960	53,147	194.10
194.20 07952	OTHER NON-REIMBURSABLE	0	0	0	0	194.20
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)	1,920,517	9,584,207	7,189,927	18,694,651	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/29/2015 8:44 am	
Cost Center Description			ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	BIOMEDICAL SERVICES	
			5.04	5.05	5.06	6.00	6.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00570	ADMINISTRATIVE	55,285					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,602				5.05
5.06	00590	ADMINISTRATIVE & GENERAL	42	2	3,272,230			5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	66,588	1,191,502		6.00
6.01	00601	BIOMEDICAL SERVICES	0	0	25,500	589	37,183	6.01
7.00	00700	OPERATION OF PLANT	0	0	113,687	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	22,974	10,206	0	8.00
9.00	00900	HOUSEKEEPING	0	0	72,494	30,813	0	9.00
10.00	01000	DIETARY	4	0	14,357	39,841	0	10.00
11.00	01100	CAFETERIA	0	0	76,509	104,215	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	61,129	589	1,011	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	49,017	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	13,496	196	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,964	143	471,553	323,436	2,702	30.00
31.00	03100	INTENSIVE CARE UNIT	711	34	142,167	65,355	714	31.00
41.00	04100	SUBPROVIDER - I RF	189	9	43,518	17,075	0	41.00
43.00	04300	NURSERY	317	15	45,429	29,635	627	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,513	439	520,007	93,224	8,211	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,444	70	41,741	22,178	472	52.00
53.00	05300	ANESTHESIOLOGY	1,313	63	13,438	0	2,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,652	227	153,107	12,953	6,495	54.00
57.00	05700	CT SCAN	5,611	271	27,174	2,159	135	57.00
58.00	05800	MRI	1,459	70	16,062	981	936	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,493	217	122,264	27,869	6,070	59.00
60.00	06000	LABORATORY	7,835	378	194,129	4,907	1,179	60.00
64.00	06400	INTRAVENOUS THERAPY	191	9	13,929	13,935	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,512	73	60,294	5,299	1,550	65.00
66.00	06600	PHYSICAL THERAPY	883	43	49,821	0	317	66.00
67.00	06700	OCCUPATIONAL THERAPY	318	15	20,599	0	168	67.00
68.00	06800	SPEECH PATHOLOGY	94	5	11,204	0	7	68.00
69.00	06900	ELECTROCARDIOLOGY	1,693	82	50,397	46,318	2,553	69.00
70.01	07001	NEUROLOGY	58	3	5,062	0	128	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,572	269	297,560	36,701	445	73.00
76.00	03950	ACUTE DIALYSIS	172	8	21,859	5,495	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	102	5	11,543	0	7	90.00
90.01	09001	DIABETES EDUCATION	3	0	998	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	63	3	5,038	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	3,077	149	158,967	88,318	707	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS								
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
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,285	2,602	3,013,611	982,287	37,183	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	3,525	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	198,158	204,504	0	192.00
192.08	19208	FOUNDATION	0	0	276	393	0	192.08
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
194.00	07950	CHILD CARE	0	0	14,862	4,318	0	194.00
194.10	07951	RETAIL PHARMACY	0	0	41,798	0	0	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.20
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)	55,285	2,602	3,272,230	1,191,502	37,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/29/2015 8:44 am				
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.04	00570	ADMINISTRATIVE					5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00590	ADMINISTRATIVE & GENERAL					5.06	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
6.01	00601	BIO MEDICAL SERVICES					6.01	
7.00	00700	OPERATION OF PLANT	1,211,123				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	18,926	157,276			8.00	
9.00	00900	HOUSEKEEPING	44,133	786	437,475		9.00	
10.00	01000	DIETARY	17,039	305	6,493	178,549	10.00	
11.00	01100	CAFETERIA	44,507	796	16,960	0	503,325	11.00
13.00	01300	NURSING ADMINISTRATION	8,444	0	3,218	4,444	11,319	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,045	0	6,876	0	15,847	16.00
17.00	01700	SOCIAL SERVICE	15,508	0	5,909	0	3,773	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	249,502	73,857	95,071	129,521	135,073	30.00
31.00	03100	INTENSIVE CARE UNIT	77,954	15,209	29,705	8,064	29,430	31.00
41.00	04100	SUBPROVIDER - IRF	40,185	7,864	15,313	6,803	9,810	41.00
43.00	04300	NURSERY	4,767	2,359	1,817	0	11,319	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	139,874	13,101	53,300	5,588	49,050	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,998	0	16,385	0	8,301	52.00
53.00	05300	ANESTHESIOLOGY	1,140	0	434	0	25,657	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,666	14,328	37,978	0	0	54.00
57.00	05700	CT SCAN	17,168	0	6,542	0	4,528	57.00
58.00	05800	MRI	9,664	3,145	3,682	0	3,018	58.00
59.00	05900	CARDIAC CATHETERIZATION	29,311	1,573	11,169	0	13,583	59.00
60.00	06000	LABORATORY	39,549	0	15,070	0	29,430	60.00
64.00	06400	INTRAVENOUS THERAPY	6,027	0	2,297	0	2,264	64.00
65.00	06500	RESPIRATORY THERAPY	6,552	0	2,497	0	18,865	65.00
66.00	06600	PHYSICAL THERAPY	16,647	0	6,344	0	14,338	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,325	0	5,840	0	4,528	67.00
68.00	06800	SPEECH PATHOLOGY	3,031	0	1,155	0	3,018	68.00
69.00	06900	ELECTROCARDIOLOGY	77,985	786	29,716	0	9,810	69.00
70.01	07001	NEUROLOGY	5,782	393	2,203	0	755	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,036	5,080	5,730	0	33,957	73.00
76.00	03950	ACUTE DIALYSIS	4,718	346	1,798	0	755	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	9,623	0	3,667	0	2,264	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	0	755	90.01
90.04	09005	ANTI COAGULATION CLINIC	4,509	0	1,718	0	755	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	69,367	16,247	26,433	2,597	39,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
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
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,152,982	156,175	415,320	152,573	481,442	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	6,334	0	2,414	0	1,509	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	14,338	192.00
192.08	19208	FOUNDATION	1,607	0	612	0	0	192.08
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
194.00	07950	CHILD CARE	44,289	1,101	16,877	25,976	3,018	194.00
194.10	07951	RETAIL PHARMACY	5,911	0	2,252	0	3,018	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.20
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)	1,211,123	157,276	437,475	178,549	503,325	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/29/2015 8:44 am	
Cost Center Description		NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adj ustments	
		13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.04	00570	ADMI TTI NG					5.04
5.05	00580	CASHI ERI NG/ACCOUNTS RECEI VABLE					5.05
5.06	00590	ADMI NI STRATI VE & GENERAL					5.06
6.00	00600	MAI NTENANCE & REPAI RS					6.00
6.01	00601	BI OMEDI CAL SERVI CES					6.01
7.00	00700	OPERATI ON OF PLANT					7.00
8.00	00800	LAUNDRY & LI NEN SERVICE					8.00
9.00	00900	HOUSEKEEPI NG					9.00
10.00	01000	DI ETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSI NG ADMI NI STRATI ON	551,704				13.00
16.00	01600	MEDI CAL RECORDS & LI BRARY	17,527	213,910			16.00
17.00	01700	SOCI AL SERVI CE	4,665	0	129,331		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDI ATRI CS	151,780	11,510	106,051	3,498,006	0 30.00
31.00	03100	I NTENSIVE CARE UNI T	33,372	2,761	0	1,011,618	0 31.00
41.00	04100	SUBPROVI DER - I RF	10,782	733	0	375,524	0 41.00
43.00	04300	NURSERY	12,778	1,232	0	183,697	0 43.00
ANCI LLARY SERVI CE COST CENTERS							
50.00	05000	OPERATI NG ROOM	55,353	40,247	0	2,751,212	0 50.00
52.00	05200	DELIV ERY ROOM & LABOR ROOM	9,530	5,608	0	451,530	0 52.00
53.00	05300	ANESTHESI OLOGY	0	5,098	0	127,103	0 53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	28,685	18,063	0	1,899,147	0 54.00
57.00	05700	CT SCAN	5,106	21,786	0	371,217	0 57.00
58.00	05800	MRI	3,236	5,665	0	149,052	0 58.00
59.00	05900	CARDI AC CATHETERI ZATI ON	15,215	17,445	0	541,688	0 59.00
60.00	06000	LABORATORY	32,865	30,423	0	849,415	0 60.00
64.00	06400	I NTRAVENOUS THERAPY	2,580	743	0	164,125	0 64.00
65.00	06500	RESPI RATORY THERAPY	21,157	5,872	0	249,965	0 65.00
66.00	06600	PHYSI CAL THERAPY	15,831	3,429	0	215,620	0 66.00
67.00	06700	OCCUPATI ONAL THERAPY	4,978	1,234	0	139,509	0 67.00
68.00	06800	SPEECH PATHOLOGY	3,124	364	0	42,375	0 68.00
69.00	06900	ELECTROCARDI OLOGY	10,949	6,574	0	772,142	0 69.00
70.01	07001	NEUROLOGY	1,137	225	0	90,078	0 70.01
71.00	07100	MEDI CAL SUPPLI ES CHARGED TO PAT	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATI ENTS	38,063	21,633	0	835,879	0 73.00
76.00	03950	ACUTE DI ALYSI S	20	668	0	69,763	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINI C	2,916	394	0	90,200	0 90.00
90.01	09001	DI ABETES EDUCATI ON	425	10	0	2,311	0 90.01
90.04	09005	ANTI COAGULATI ON CLINI C	979	245	0	38,387	0 90.04
90.05	09003	OUTPATI ENT PSYCHI ATRI C SERVI CES	0	0	0	0	0 90.05
91.00	09100	EMERGENCY	44,476	11,948	23,280	1,006,829	0 91.00
92.00	09200	OBSERVATI ON BEDS (NON-DI STI NCT					0 92.00
OTHER REI MBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATI ENT PHYSI CAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATI ENT OCCUPATI ONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATI ENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LI NES 1-117)	527,529	213,910	129,331	15,926,392	0 118.00
NONREI MBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,766	0	0	51,806	0 190.00
192.00	19200	PHYSI CI ANS PRI VATE OFFI CES	16,164	0	0	2,232,261	0 192.00
192.08	19208	FOUNDATI ON	0	0	0	16,225	0 192.08
193.06	19306	OUTSI DE ACCOUNTI NG	0	0	0	0	0 193.06
194.00	07950	CHI LD CARE	3,249	0	0	357,311	0 194.00
194.10	07951	RETAI L PHARMACY	2,996	0	0	110,656	0 194.10
194.20	07952	OTHER NON-REI MBURSABLE	0	0	0	0	0 194.20
200.00		Cross Foot Adj ustments				0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	551,704	213,910	129,331	18,694,651	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/29/2015 8:44 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	5.06
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
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
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
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
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
76.00	03950	ACUTE DIALYSIS	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	DIABETES EDUCATION	90.01
90.04	09005	ANTI COAGULATION CLINIC	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	90.05
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	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
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
192.08	19208	FOUNDATION	192.08
193.06	19306	OUTSIDE ACCOUNTING	193.06
194.00	07950	CHILD CARE	194.00
194.10	07951	RETAIL PHARMACY	194.10
194.20	07952	OTHER NON-REIMBURSABLE	194.20
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1
Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (ADMITTING CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	395,435					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		4,974,720				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	9,737	0	42,479,941			4.00
5.04 00570 ADMITTING	2,281	0	0	380,228,327		5.04
5.05 00580 CASHIERING/ACCOUNTS RECEIVABLE	0	1,800	0	0	380,635,732	5.05
5.06 00590 ADMINISTRATIVE & GENERAL	49,653	1,098,542	4,319,111	291,261	291,261	5.06
6.00 00600 MAINTENANCE & REPAIRS	46,317	0	418,149	0	0	6.00
6.01 00601 BIOMEDICAL SERVICES	267	3,199	0	0	0	6.01
7.00 00700 OPERATION OF PLANT	15,090	471,771	451,044	0	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	4,252	974	127,149	0	0	8.00
9.00 00900 HOUSEKEEPING	9,915	29,471	1,142,060	0	0	9.00
10.00 01000 DIETARY	3,828	3,273	540,067	26,964	26,964	10.00
11.00 01100 CAFETERIA	9,999	8,551	1,013,870	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	1,897	286,719	1,012,295	0	0	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	4,054	2,692	801,122	1,272	1,272	16.00
17.00 01700 SOCIAL SERVICE	3,484	0	241,536	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	56,052	60,403	8,548,586	20,444,317	20,444,317	30.00
31.00 03100 INTENSIVE CARE UNIT	17,513	109,272	2,395,256	4,903,771	4,903,771	31.00
41.00 04100 SUBPROVIDER - IRF	9,028	0	797,547	1,301,811	1,301,811	41.00
43.00 04300 NURSERY	1,071	29,552	852,001	2,187,543	2,187,543	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	31,424	641,757	3,636,888	71,448,262	71,448,262	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	9,660	22,041	635,437	9,961,383	9,961,383	52.00
53.00 05300 ANESTHESIOLOGY	256	45,836	0	9,055,255	9,055,255	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	22,391	640,176	1,829,900	32,082,661	32,490,066	54.00
57.00 05700 CT SCAN	3,857	128,250	324,548	38,695,404	38,695,404	57.00
58.00 05800 MRI	2,171	32,651	238,457	10,062,759	10,062,759	58.00
59.00 05900 CARDIAC CATHETERIZATION	6,585	53,864	937,335	30,985,074	30,985,074	59.00
60.00 06000 LABORATORY	8,885	186,053	1,561,486	54,037,567	54,037,567	60.00
64.00 06400 INTRAVENOUS THERAPY	1,354	1,159	194,595	1,319,557	1,319,557	64.00
65.00 06500 RESPIRATORY THERAPY	1,472	43,767	1,146,200	10,430,506	10,430,506	65.00
66.00 06600 PHYSICAL THERAPY	3,740	7,279	1,018,915	6,090,807	6,090,807	66.00
67.00 06700 OCCUPATIONAL THERAPY	3,443	604	392,909	2,192,042	2,192,042	67.00
68.00 06800 SPEECH PATHOLOGY	681	1,782	232,672	645,943	645,943	68.00
69.00 06900 ELECTROCARDIOLOGY	17,520	74,115	610,796	11,677,175	11,677,175	69.00
70.01 07001 NEUROLOGY	1,299	13,247	65,281	399,590	399,590	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,378	41,409	2,804,164	38,424,694	38,424,694	73.00
76.00 03950 ACUTE DIALYSIS	1,060	5,634	16,251	1,187,110	1,187,110	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	2,162	4,345	169,630	700,369	700,369	90.00
90.01 09001 DIABETES EDUCATION	0	0	21,685	17,922	17,922	90.01
90.04 09005 ANTI COAGULATION CLINIC	1,013	0	94,486	436,037	436,037	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00 09100 EMERGENCY	15,584	73,849	2,924,696	21,221,271	21,221,271	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS						
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
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	382,373	4,124,037	41,516,124	380,228,327	380,635,732	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	1,423	1,052	44,895	0	0	190.00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	833,841	534,801	0	0	192.00
192.08 19208 FOUNDATION	361	0	0	0	0	192.08
193.06 19306 OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
194.00 07950 CHILD CARE	9,950	1,288	108,043	0	0	194.00
194.10 07951 RETAIL PHARMACY	1,328	14,502	276,078	0	0	194.10
194.20 07952 OTHER NON-REIMBURSABLE	0	0	0	0	0	194.20
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)	9,584,207	7,189,927	18,177,172	55,288	3,791	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	24.237124	1.445293	0.427900	0.000145	0.000010	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (ADMITTING CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
		BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
204.00	Cost to be allocated (per Wkst. B, Part II)			235,997	55,285	2,602	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.005555	0.000145	0.000007	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
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	869,307				8.00
9.00	00900	HOUSEKEEPING	4,347	257,923			9.00
10.00	01000	DIETARY	1,685	3,828	165,267		10.00
11.00	01100	CAFETERIA	4,401	9,999	0	667	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,897	0	15	1,350,095
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,054	0	21	42,891
17.00	01700	SOCIAL SERVICE	0	3,484	0	5	11,415
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	408,226	56,052	119,886	179	371,432
31.00	03100	INTENSIVE CARE UNIT	84,062	17,513	7,464	39	81,667
41.00	04100	SUBPROVIDER - IIRF	43,465	9,028	6,297	13	26,385
43.00	04300	NURSERY	13,040	1,071	0	15	31,269
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	72,413	31,424	5,172	65	135,456
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,660	0	11	23,322
53.00	05300	ANESTHESIOLOGY	0	256	0	34	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,194	22,391	0	0	70,195
57.00	05700	CT SCAN	0	3,857	0	6	12,496
58.00	05800	MRI	17,386	2,171	0	4	7,918
59.00	05900	CARDIAC CATHETERIZATION	8,693	6,585	0	18	37,234
60.00	06000	LABORATORY	0	8,885	0	39	80,425
64.00	06400	INTRAVENOUS THERAPY	0	1,354	0	3	6,314
65.00	06500	RESPIRATORY THERAPY	0	1,472	0	25	51,774
66.00	06600	PHYSICAL THERAPY	0	3,740	0	19	38,740
67.00	06700	OCCUPATIONAL THERAPY	0	3,443	0	6	12,181
68.00	06800	SPEECH PATHOLOGY	0	681	0	4	7,645
69.00	06900	ELECTROCARDIOLOGY	4,347	17,520	0	13	26,793
70.01	07001	NEUROLOGY	2,173	1,299	0	1	2,782
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	28,079	3,378	0	45	93,146
76.00	03950	ACUTE DIALYSIS	1,912	1,060	0	1	48
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	2,162	0	3	7,135
90.01	09001	DIABETES EDUCATION	0	0	0	1	1,039
90.04	09005	ANTI COAGULATION CLINIC	0	1,013	0	1	2,395
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0
91.00	09100	EMERGENCY	89,799	15,584	2,404	52	108,839
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	863,222	244,861	141,223	638	1,290,936
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	1,423	0	2	4,322
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	19	39,556
192.08	19208	FOUNDATION	0	361	0	0	0
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0
194.00	07950	CHILD CARE	6,085	9,950	24,044	4	7,950
194.10	07951	RETAIL PHARMACY	0	1,328	0	4	7,331
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,110,881	3,443,315	850,966	3,934,554	2,862,311
203.00		Unit cost multiplier (Wkst. B, Part I)	1.277893	13.350167	5.149038	5,898.881559	2.120081
204.00		Cost to be allocated (per Wkst. B, Part II)	157,276	437,475	178,549	503,325	551,704

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1

Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.180921	1.696146	1.080367	754.610195	0.408641	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1
Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.04	00570			5.04
5.05	00580			5.05
5.06	00590			5.06
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			10.00
11.00	01100			11.00
13.00	01300			13.00
16.00	01600	379,908,830		16.00
17.00	01700	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	20,444,317	82	30.00
31.00	03100	4,903,771	0	31.00
41.00	04100	1,301,811	0	41.00
43.00	04300	2,187,543	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	71,448,262	0	50.00
52.00	05200	9,961,383	0	52.00
53.00	05300	9,055,255	0	53.00
54.00	05400	32,082,661	0	54.00
57.00	05700	38,695,404	0	57.00
58.00	05800	10,062,759	0	58.00
59.00	05900	30,985,074	0	59.00
60.00	06000	54,037,567	0	60.00
64.00	06400	1,319,557	0	64.00
65.00	06500	10,430,506	0	65.00
66.00	06600	6,090,807	0	66.00
67.00	06700	2,192,042	0	67.00
68.00	06800	645,943	0	68.00
69.00	06900	11,677,175	0	69.00
70.01	07001	399,590	0	70.01
71.00	07100	0	0	71.00
73.00	07300	38,424,694	0	73.00
76.00	03950	1,187,110	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	700,369	0	90.00
90.01	09001	17,922	0	90.01
90.04	09005	436,037	0	90.04
90.05	09003	0	0	90.05
91.00	09100	21,221,271	18	91.00
92.00	09200			92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	0	0	99.10
99.20	09920	0	0	99.20
99.30	09930	0	0	99.30
99.40	09940	0	0	99.40
SPECIAL PURPOSE COST CENTERS				
118.00		379,908,830	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
192.00	19200	0	0	192.00
192.08	19208	0	0	192.08
193.06	19306	0	0	193.06
194.00	07950	0	0	194.00
194.10	07951	0	0	194.10
194.20	07952	0	0	194.20
200.00				200.00
201.00				201.00
202.00		2,493,703	756,632	202.00
203.00		0.006564	7,566.320000	203.00
204.00		213,910	129,331	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
205.00	Unit cost multiplier (Wkst. B, Part II)	16.00 0.000563	17.00 1,293.310000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/29/2015 8:44 am	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		27,075,187		0	27,075,187	30.00
31.00	03100 INTENSIVE CARE UNIT		7,554,978		12,418	7,567,396	31.00
41.00	04100 SUBPROVIDER - I RF		2,466,245		5,683	2,471,928	41.00
43.00	04300 NURSERY		2,304,315		0	2,304,315	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		25,543,092		0	25,543,092	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,385,617		0	2,385,617	52.00
53.00	05300 ANESTHESIOLOGY		940,491		46,439	986,930	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		8,114,556		11,110	8,125,666	54.00
57.00	05700 CT SCAN		1,639,619		0	1,639,619	57.00
58.00	05800 MRI		932,733		0	932,733	58.00
59.00	05900 CARDIAC CATHETERIZATION		6,223,415		0	6,223,415	59.00
60.00	06000 LABORATORY		9,601,176		47,023	9,648,199	60.00
64.00	06400 INTRAVENOUS THERAPY		727,898		0	727,898	64.00
65.00	06500 RESPIRATORY THERAPY	0	3,077,240		7,436	3,084,676	65.00
66.00	06600 PHYSICAL THERAPY	0	2,547,973		0	2,547,973	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,093,469		0	1,093,469	67.00
68.00	06800 SPEECH PATHOLOGY	0	557,369		0	557,369	68.00
69.00	06900 ELECTROCARDIOLOGY		3,172,271		54,028	3,226,299	69.00
70.01	07001 NEUROLOGY		284,266		7,009	291,275	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		0		0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		14,016,011		0	14,016,011	73.00
76.00	03950 ACUTE DIALYSIS		1,022,284		8,876	1,031,160	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		612,540		0	612,540	90.00
90.01	09001 DIABETES EDUCATION		52,008		0	52,008	90.01
90.04	09005 ANTI COAGULATION CLINIC		266,951		0	266,951	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES		0		0	0	90.05
91.00	09100 EMERGENCY		8,645,901		0	8,645,901	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		2,279,875		0	2,279,875	92.00
OTHER REIMBURSABLE COST CENTERS							
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)		133,137,480	0	200,022	133,337,502	200.00
201.00	Less Observation Beds		2,279,875			2,279,875	201.00
202.00	Total (see instructions)		130,857,605	0	200,022	131,057,627	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 8:44 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,735,578		20,735,578	30.00
31.00	03100	INTENSIVE CARE UNIT	4,903,771		4,903,771	31.00
41.00	04100	SUBPROVIDER - IRF	1,301,811		1,301,811	41.00
43.00	04300	NURSERY	2,187,543		2,187,543	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,602,335	30,847,199	71,449,534	0.357498 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,525,212	3,436,171	9,961,383	0.239487 52.00
53.00	05300	ANESTHESIOLOGY	4,958,987	4,096,268	9,055,255	0.103861 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,140,337	24,349,729	32,490,066	0.249755 54.00
57.00	05700	CT SCAN	10,789,628	27,905,776	38,695,404	0.042372 57.00
58.00	05800	MRI	1,308,910	8,753,849	10,062,759	0.092692 58.00
59.00	05900	CARDIAC CATHETERIZATION	17,409,548	13,575,526	30,985,074	0.200852 59.00
60.00	06000	LABORATORY	29,482,742	24,554,825	54,037,567	0.177676 60.00
64.00	06400	INTRAVENOUS THERAPY	12,568	1,306,989	1,319,557	0.551623 64.00
65.00	06500	RESPIRATORY THERAPY	9,643,229	787,277	10,430,506	0.295023 65.00
66.00	06600	PHYSICAL THERAPY	4,498,614	1,592,193	6,090,807	0.418331 66.00
67.00	06700	OCCUPATIONAL THERAPY	1,895,061	296,982	2,192,043	0.498836 67.00
68.00	06800	SPEECH PATHOLOGY	318,945	326,998	645,943	0.862876 68.00
69.00	06900	ELECTROCARDIOLOGY	5,514,711	6,162,464	11,677,175	0.271664 69.00
70.01	07001	NEUROLOGY	180,727	218,863	399,590	0.711394 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0.000000 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,766,974	11,657,720	38,424,694	0.364766 73.00
76.00	03950	ACUTE DIALYSIS	1,140,581	46,529	1,187,110	0.861154 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,265	720,068	727,333	0.842173 90.00
90.01	09001	DIABETES EDUCATION	0	17,922	17,922	2.901908 90.01
90.04	09005	ANTI COAGULATION CLINIC	928	435,109	436,037	0.612221 90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0.000000 90.05
91.00	09100	EMERGENCY	5,148,799	16,072,472	21,221,271	0.407417 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,516,577	1,516,577	1.503303 92.00
OTHER REIMBURSABLE COST CENTERS						
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)	203,474,804	178,677,506	382,152,310	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	203,474,804	178,677,506	382,152,310	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 8:44 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.357498		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.239487		52.00
53.00	05300 ANESTHESIOLOGY	0.108990		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.250097		54.00
57.00	05700 CT SCAN	0.042372		57.00
58.00	05800 MRI	0.092692		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.200852		59.00
60.00	06000 LABORATORY	0.178546		60.00
64.00	06400 INTRAVENOUS THERAPY	0.551623		64.00
65.00	06500 RESPIRATORY THERAPY	0.295736		65.00
66.00	06600 PHYSICAL THERAPY	0.418331		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.498836		67.00
68.00	06800 SPEECH PATHOLOGY	0.862876		68.00
69.00	06900 ELECTROCARDIOLOGY	0.276291		69.00
70.01	07001 NEUROLOGY	0.728935		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.364766		73.00
76.00	03950 ACUTE DIALYSIS	0.868631		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.842173		90.00
90.01	09001 DIABETES EDUCATION	2.901908		90.01
90.04	09005 ANTI COAGULATION CLINIC	0.612221		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000		90.05
91.00	09100 EMERGENCY	0.407417		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.503303		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: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/29/2015 8:44 am	
		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		27,075,187	0	27,075,187	30.00	
31.00	03100 INTENSIVE CARE UNIT		7,554,978	12,418	7,567,396	31.00	
41.00	04100 SUBPROVIDER - I RF		2,466,245	5,683	2,471,928	41.00	
43.00	04300 NURSERY		2,304,315	0	2,304,315	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		25,543,092	0	25,543,092	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		2,385,617	0	2,385,617	52.00	
53.00	05300 ANESTHESIOLOGY		940,491	46,439	986,930	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		8,114,556	11,110	8,125,666	54.00	
57.00	05700 CT SCAN		1,639,619	0	1,639,619	57.00	
58.00	05800 MRI		932,733	0	932,733	58.00	
59.00	05900 CARDIAC CATHETERIZATION		6,223,415	0	6,223,415	59.00	
60.00	06000 LABORATORY		9,601,176	47,023	9,648,199	60.00	
64.00	06400 INTRAVENOUS THERAPY		727,898	0	727,898	64.00	
65.00	06500 RESPIRATORY THERAPY	0	3,077,240	7,436	3,084,676	65.00	
66.00	06600 PHYSICAL THERAPY	0	2,547,973	0	2,547,973	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	1,093,469	0	1,093,469	67.00	
68.00	06800 SPEECH PATHOLOGY	0	557,369	0	557,369	68.00	
69.00	06900 ELECTROCARDIOLOGY		3,172,271	54,028	3,226,299	69.00	
70.01	07001 NEUROLOGY		284,266	7,009	291,275	70.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		0	0	0	71.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		14,016,011	0	14,016,011	73.00	
76.00	03950 ACUTE DIALYSIS		1,022,284	8,876	1,031,160	76.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		612,540	0	612,540	90.00	
90.01	09001 DIABETES EDUCATION		52,008	0	52,008	90.01	
90.04	09005 ANTI COAGULATION CLINIC		266,951	0	266,951	90.04	
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES		0	0	0	90.05	
91.00	09100 EMERGENCY		8,645,901	0	8,645,901	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT		2,279,875	0	2,279,875	92.00	
OTHER REIMBURSABLE COST CENTERS							
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)		133,137,480	200,022	133,337,502	200.00	
201.00	Less Observation Beds		2,279,875	0	2,279,875	201.00	
202.00	Total (see instructions)		130,857,605	200,022	131,057,627	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/29/2015 8:44 am	
			Title XIX		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,735,578		20,735,578			30.00
31.00	03100	INTENSIVE CARE UNIT	4,903,771		4,903,771			31.00
41.00	04100	SUBPROVIDER - IRF	1,301,811		1,301,811			41.00
43.00	04300	NURSERY	2,187,543		2,187,543			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,602,335	30,847,199	71,449,534	0.357498	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,525,212	3,436,171	9,961,383	0.239487	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,958,987	4,096,268	9,055,255	0.103861	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,140,337	24,349,729	32,490,066	0.249755	0.000000	54.00
57.00	05700	CT SCAN	10,789,628	27,905,776	38,695,404	0.042372	0.000000	57.00
58.00	05800	MRI	1,308,910	8,753,849	10,062,759	0.092692	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,409,548	13,575,526	30,985,074	0.200852	0.000000	59.00
60.00	06000	LABORATORY	29,482,742	24,554,825	54,037,567	0.177676	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	12,568	1,306,989	1,319,557	0.551623	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	9,643,229	787,277	10,430,506	0.295023	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,498,614	1,592,193	6,090,807	0.418331	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,895,061	296,982	2,192,043	0.498836	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	318,945	326,998	645,943	0.862876	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,514,711	6,162,464	11,677,175	0.271664	0.000000	69.00
70.01	07001	NEUROLOGY	180,727	218,863	399,590	0.711394	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,766,974	11,657,720	38,424,694	0.364766	0.000000	73.00
76.00	03950	ACUTE DIALYSIS	1,140,581	46,529	1,187,110	0.861154	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,265	720,068	727,333	0.842173	0.000000	90.00
90.01	09001	DIABETES EDUCATION	0	17,922	17,922	2.901908	0.000000	90.01
90.04	09005	ANTI COAGULATION CLINIC	928	435,109	436,037	0.612221	0.000000	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0.000000	0.000000	90.05
91.00	09100	EMERGENCY	5,148,799	16,072,472	21,221,271	0.407417	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,516,577	1,516,577	1.503303	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
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)	203,474,804	178,677,506	382,152,310			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	203,474,804	178,677,506	382,152,310			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/29/2015 8:44 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.357498		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.239487		52.00
53.00	05300 ANESTHESIOLOGY	0.108990		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.250097		54.00
57.00	05700 CT SCAN	0.042372		57.00
58.00	05800 MRI	0.092692		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.200852		59.00
60.00	06000 LABORATORY	0.178546		60.00
64.00	06400 INTRAVENOUS THERAPY	0.551623		64.00
65.00	06500 RESPIRATORY THERAPY	0.295736		65.00
66.00	06600 PHYSICAL THERAPY	0.418331		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.498836		67.00
68.00	06800 SPEECH PATHOLOGY	0.862876		68.00
69.00	06900 ELECTROCARDIOLOGY	0.276291		69.00
70.01	07001 NEUROLOGY	0.728935		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.364766		73.00
76.00	03950 ACUTE DIALYSIS	0.868631		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.842173		90.00
90.01	09001 DIABETES EDUCATION	2.901908		90.01
90.04	09005 ANTI COAGULATION CLINIC	0.612221		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000		90.05
91.00	09100 EMERGENCY	0.407417		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.503303		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

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

Provider CCN: 140046

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

Worksheet C Part II Date/Time Prepared: 5/29/2015 8:44 am

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,543,092	2,751,212	22,791,880	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,385,617	451,530	1,934,087	0	0	52.00
53.00	05300	ANESTHESIOLOGY	940,491	127,103	813,388	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,114,556	1,899,147	6,215,409	0	0	54.00
57.00	05700	CT SCAN	1,639,619	371,217	1,268,402	0	0	57.00
58.00	05800	MRI	932,733	149,052	783,681	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,223,415	541,688	5,681,727	0	0	59.00
60.00	06000	LABORATORY	9,601,176	849,415	8,751,761	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	727,898	164,125	563,773	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,077,240	249,965	2,827,275	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,547,973	215,620	2,332,353	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,093,469	139,509	953,960	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	557,369	42,375	514,994	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,172,271	772,142	2,400,129	0	0	69.00
70.01	07001	NEUROLOGY	284,266	90,078	194,188	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	14,016,011	835,879	13,180,132	0	0	73.00
76.00	03950	ACUTE DIALYSIS	1,022,284	69,763	952,521	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	612,540	90,200	522,340	0	0	90.00
90.01	09001	DIABETES EDUCATION	52,008	2,311	49,697	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	266,951	38,387	228,564	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	8,645,901	1,006,829	7,639,072	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	2,279,875	294,551	1,985,324	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
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)	93,736,755	11,152,098	82,584,657	0	0	200.00
201.00		Less Observation Beds	2,279,875	294,551	1,985,324	0	0	201.00
202.00		Total (line 200 minus line 201)	91,456,880	10,857,547	80,599,333	0	0	202.00

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

Provider CCN: 140046

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

Worksheet C Part II Date/Time Prepared: 5/29/2015 8:44 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	25,543,092	71,449,534	0.357498		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,385,617	9,961,383	0.239487		52.00
53.00	05300 ANESTHESIOLOGY	940,491	9,055,255	0.103861		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,114,556	32,490,066	0.249755		54.00
57.00	05700 CT SCAN	1,639,619	38,695,404	0.042372		57.00
58.00	05800 MRI	932,733	10,062,759	0.092692		58.00
59.00	05900 CARDIAC CATHETERIZATION	6,223,415	30,985,074	0.200852		59.00
60.00	06000 LABORATORY	9,601,176	54,037,567	0.177676		60.00
64.00	06400 INTRAVENOUS THERAPY	727,898	1,319,557	0.551623		64.00
65.00	06500 RESPIRATORY THERAPY	3,077,240	10,430,506	0.295023		65.00
66.00	06600 PHYSICAL THERAPY	2,547,973	6,090,807	0.418331		66.00
67.00	06700 OCCUPATIONAL THERAPY	1,093,469	2,192,043	0.498836		67.00
68.00	06800 SPEECH PATHOLOGY	557,369	645,943	0.862876		68.00
69.00	06900 ELECTROCARDIOLOGY	3,172,271	11,677,175	0.271664		69.00
70.01	07001 NEUROLOGY	284,266	399,590	0.711394		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	14,016,011	38,424,694	0.364766		73.00
76.00	03950 ACUTE DIALYSIS	1,022,284	1,187,110	0.861154		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	612,540	727,333	0.842173		90.00
90.01	09001 DIABETES EDUCATION	52,008	17,922	2.901908		90.01
90.04	09005 ANTI COAGULATION CLINIC	266,951	436,037	0.612221		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000		90.05
91.00	09100 EMERGENCY	8,645,901	21,221,271	0.407417		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,279,875	1,516,577	1.503303		92.00
OTHER REIMBURSABLE COST CENTERS						
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)	93,736,755	353,023,607			200.00
201.00	Less Observation Beds	2,279,875	0			201.00
202.00	Total (line 200 minus line 201)	91,456,880	353,023,607			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/29/2015 8:44 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)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,498,006	0	3,498,006	25,711	136.05	30.00
31.00	INTENSIVE CARE UNIT	1,011,618		1,011,618	3,129	323.30	31.00
41.00	SUBPROVIDER - IRF	375,524	0	375,524	1,933	194.27	41.00
43.00	NURSERY	183,697		183,697	1,888	97.30	43.00
200.00	Total (lines 30-199)	5,068,845		5,068,845	32,661		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	13,527	1,840,348				
31.00	INTENSIVE CARE UNIT	1,767	571,271				
41.00	SUBPROVIDER - IRF	1,266	245,946				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	16,560	2,657,565				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 8:44 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	2,751,212	71,449,534	0.038506	21,102,794	812,584	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	451,530	9,961,383	0.045328	27,364	1,240	52.00
53.00	05300 ANESTHESIOLOGY	127,103	9,055,255	0.014036	1,654,869	23,228	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,899,147	32,490,066	0.058453	4,952,829	289,508	54.00
57.00	05700 CT SCAN	371,217	38,695,404	0.009593	6,120,266	58,712	57.00
58.00	05800 MRI	149,052	10,062,759	0.014812	602,096	8,918	58.00
59.00	05900 CARDIAC CATHETERIZATION	541,688	30,985,074	0.017482	8,689,462	151,909	59.00
60.00	06000 LABORATORY	849,415	54,037,567	0.015719	16,035,117	252,056	60.00
64.00	06400 INTRAVENOUS THERAPY	164,125	1,319,557	0.124379	8,243	1,025	64.00
65.00	06500 RESPIRATORY THERAPY	249,965	10,430,506	0.023965	5,813,807	139,328	65.00
66.00	06600 PHYSICAL THERAPY	215,620	6,090,807	0.035401	2,278,553	80,663	66.00
67.00	06700 OCCUPATIONAL THERAPY	139,509	2,192,043	0.063643	550,589	35,041	67.00
68.00	06800 SPEECH PATHOLOGY	42,375	645,943	0.065602	142,563	9,352	68.00
69.00	06900 ELECTROCARDIOLOGY	772,142	11,677,175	0.066124	3,454,997	228,458	69.00
70.01	07001 NEUROLOGY	90,078	399,590	0.225426	116,469	26,255	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	835,879	38,424,694	0.021754	14,475,020	314,890	73.00
76.00	03950 ACUTE DIALYSIS	69,763	1,187,110	0.058767	865,643	50,871	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	90,200	727,333	0.124015	0	0	90.00
90.01	09001 DIABETES EDUCATION	2,311	17,922	0.128948	0	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	38,387	436,037	0.088036	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0	0	90.05
91.00	09100 EMERGENCY	1,006,829	21,221,271	0.047444	2,900,878	137,629	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	294,551	1,516,577	0.194221	0	0	92.00
200.00	Total (lines 50-199)	11,152,098	353,023,607		89,791,559	2,621,667	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/29/2015 8:44 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	25,711	0.00	13,527	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,129	0.00	1,767	0		31.00
41.00	04100	SUBPROVIDER - IRF	1,933	0.00	1,266	0		41.00
43.00	04300	NURSERY	1,888	0.00	0	0		43.00
200.00		Total (lines 30-199)	32,661		16,560	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	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
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03950	ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
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: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	71,449,534	0.000000	0.000000	21,102,794	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	9,961,383	0.000000	0.000000	27,364	52.00
53.00	05300 ANESTHESIOLOGY	0	9,055,255	0.000000	0.000000	1,654,869	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,490,066	0.000000	0.000000	4,952,829	54.00
57.00	05700 CT SCAN	0	38,695,404	0.000000	0.000000	6,120,266	57.00
58.00	05800 MRI	0	10,062,759	0.000000	0.000000	602,096	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	30,985,074	0.000000	0.000000	8,689,462	59.00
60.00	06000 LABORATORY	0	54,037,567	0.000000	0.000000	16,035,117	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,319,557	0.000000	0.000000	8,243	64.00
65.00	06500 RESPIRATORY THERAPY	0	10,430,506	0.000000	0.000000	5,813,807	65.00
66.00	06600 PHYSICAL THERAPY	0	6,090,807	0.000000	0.000000	2,278,553	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,192,043	0.000000	0.000000	550,589	67.00
68.00	06800 SPEECH PATHOLOGY	0	645,943	0.000000	0.000000	142,563	68.00
69.00	06900 ELECTROCARDIOLOGY	0	11,677,175	0.000000	0.000000	3,454,997	69.00
70.01	07001 NEUROLOGY	0	399,590	0.000000	0.000000	116,469	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	38,424,694	0.000000	0.000000	14,475,020	73.00
76.00	03950 ACUTE DIALYSIS	0	1,187,110	0.000000	0.000000	865,643	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	727,333	0.000000	0.000000	0	90.00
90.01	09001 DIABETES EDUCATION	0	17,922	0.000000	0.000000	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	0	436,037	0.000000	0.000000	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	90.05
91.00	09100 EMERGENCY	0	21,221,271	0.000000	0.000000	2,900,878	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	1,516,577	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	353,023,607			89,791,559	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	8,865,888	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	12,190	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,178,250	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	11,110,080	0	54.00
57.00	05700 CT SCAN	0	8,986,589	0	57.00
58.00	05800 MRI	0	2,868,042	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	7,813,166	0	59.00
60.00	06000 LABORATORY	0	5,202,530	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	696,318	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	372,247	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,708,206	0	69.00
70.01	07001 NEUROLOGY	0	69,375	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,873,783	0	73.00
76.00	03950 ACUTE DIALYSIS	0	44,051	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 DIABETES EDUCATION	0	411	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	0	257,376	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	90.05
91.00	09100 EMERGENCY	0	3,311,667	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	1,481,583	0	92.00
200.00	Total (lines 50-199)	0	59,851,752	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 8:44 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.357498	8,865,888	0	0	3,169,537 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.239487	12,190	0	0	2,919 52.00
53.00	05300 ANESTHESIOLOGY	0.103861	1,178,250	0	0	122,374 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.249755	11,110,080	0	2,505	2,774,798 54.00
57.00	05700 CT SCAN	0.042372	8,986,589	0	13,386	380,780 57.00
58.00	05800 MRI	0.092692	2,868,042	0	8,222	265,845 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.200852	7,813,166	0	0	1,569,290 59.00
60.00	06000 LABORATORY	0.177676	5,202,530	0	457	924,365 60.00
64.00	06400 INTRAVENOUS THERAPY	0.551623	696,318	0	0	384,105 64.00
65.00	06500 RESPIRATORY THERAPY	0.295023	372,247	0	0	109,821 65.00
66.00	06600 PHYSICAL THERAPY	0.418331	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.498836	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.862876	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.271664	2,708,206	0	0	735,722 69.00
70.01	07001 NEUROLOGY	0.711394	69,375	0	0	49,353 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	0.364766	4,873,783	0	163,383	1,777,790 73.00
76.00	03950 ACUTE DIALYSIS	0.861154	44,051	0	0	37,935 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.842173	0	0	0	0 90.00
90.01	09001 DIABETES EDUCATION	2.901908	411	0	0	1,193 90.01
90.04	09005 ANTI COAGULATION CLINIC	0.612221	257,376	0	0	157,571 90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	0	0	0 90.05
91.00	09100 EMERGENCY	0.407417	3,311,667	0	0	1,349,229 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1.503303	1,481,583	0	0	2,227,268 92.00
200.00	Subtotal (see instructions)		59,851,752	0	187,953	16,039,895 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		59,851,752	0	187,953	16,039,895 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 8:44 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		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	626		54.00
57.00 05700 CT SCAN	0	567		57.00
58.00 05800 MRI	0	762		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	81		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
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	59,597		73.00
76.00 03950 ACUTE DIALYSIS	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 DIABETES EDUCATION	0	0		90.01
90.04 09005 ANTI COAGULATION CLINIC	0	0		90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0		90.05
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	61,633		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	61,633		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140046 Component CCN: 14T046		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/29/2015 8:44 am		
		Title XVIII		Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,751,212	71,449,534	0.038506	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	451,530	9,961,383	0.045328	0	0	52.00
53.00	05300	ANESTHESIOLOGY	127,103	9,055,255	0.014036	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,899,147	32,490,066	0.058453	15,833	925	54.00
57.00	05700	CT SCAN	371,217	38,695,404	0.009593	8,196	79	57.00
58.00	05800	MRI	149,052	10,062,759	0.014812	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	541,688	30,985,074	0.017482	0	0	59.00
60.00	06000	LABORATORY	849,415	54,037,567	0.015719	133,025	2,091	60.00
64.00	06400	INTRAVENOUS THERAPY	164,125	1,319,557	0.124379	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	249,965	10,430,506	0.023965	63,969	1,533	65.00
66.00	06600	PHYSICAL THERAPY	215,620	6,090,807	0.035401	750,227	26,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,509	2,192,043	0.063643	715,573	45,541	67.00
68.00	06800	SPEECH PATHOLOGY	42,375	645,943	0.065602	68,858	4,517	68.00
69.00	06900	ELECTROCARDIOLOGY	772,142	11,677,175	0.066124	4,562	302	69.00
70.01	07001	NEUROLOGY	90,078	399,590	0.225426	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	835,879	38,424,694	0.021754	165,085	3,591	73.00
76.00	03950	ACUTE DIALYSIS	69,763	1,187,110	0.058767	8,617	506	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	90,200	727,333	0.124015	0	0	90.00
90.01	09001	DIABETES EDUCATION	2,311	17,922	0.128948	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	38,387	436,037	0.088036	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0	0	90.05
91.00	09100	EMERGENCY	1,006,829	21,221,271	0.047444	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,516,577	0.000000	0	0	92.00
200.00		Total (lines 50-199)	10,857,547	353,023,607		1,933,945	85,644	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 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
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 DIABETES EDUCATION	0	0	0	0	0	90.01
90.04	09005 ANTICOAGULATION CLINIC	0	0	0	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
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: 140046 Component CCN: 14T046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
Title XVIII		Subprovider - IRF	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
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	71,449,534	0.000000	0.000000	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	9,961,383	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	9,055,255	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	32,490,066	0.000000	0.000000	15,833 54.00
57.00 05700 CT SCAN	0	38,695,404	0.000000	0.000000	8,196 57.00
58.00 05800 MRI	0	10,062,759	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	30,985,074	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	54,037,567	0.000000	0.000000	133,025 60.00
64.00 06400 INTRAVENOUS THERAPY	0	1,319,557	0.000000	0.000000	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	10,430,506	0.000000	0.000000	63,969 65.00
66.00 06600 PHYSICAL THERAPY	0	6,090,807	0.000000	0.000000	750,227 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	2,192,043	0.000000	0.000000	715,573 67.00
68.00 06800 SPEECH PATHOLOGY	0	645,943	0.000000	0.000000	68,858 68.00
69.00 06900 ELECTROCARDIOLOGY	0	11,677,175	0.000000	0.000000	4,562 69.00
70.01 07001 NEUROLOGY	0	399,590	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	38,424,694	0.000000	0.000000	165,085 73.00
76.00 03950 ACUTE DIALYSIS	0	1,187,110	0.000000	0.000000	8,617 76.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	727,333	0.000000	0.000000	0 90.00
90.01 09001 DIABETES EDUCATION	0	17,922	0.000000	0.000000	0 90.01
90.04 09005 ANTI COAGULATION CLINIC	0	436,037	0.000000	0.000000	0 90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0 90.05
91.00 09100 EMERGENCY	0	21,221,271	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	1,516,577	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	353,023,607			1,933,945 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
	Component CCN: 14T046	Title XVIII	Subprovider - IRF

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
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
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
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
76.00 03950 ACUTE DIALYSIS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 DIABETES EDUCATION	0	0	0	90.01
90.04 09005 ANTICOAGULATION CLINIC	0	0	0	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	90.05
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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 8:44 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	PPS Services (see inst.)	
		Cost Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.357498	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.239487	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.103861	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.249755	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0.042372	0	0	0	0	0	57.00
58.00 05800 MRI	0.092692	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.200852	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0.177676	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0.551623	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.295023	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.418331	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.498836	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.862876	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.271664	0	0	0	0	0	69.00
70.01 07001 NEUROLOGY	0.711394	0	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.364766	0	0	0	0	0	73.00
76.00 03950 ACUTE DIALYSIS	0.861154	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.842173	0	0	0	0	0	90.00
90.01 09001 DIABETES EDUCATION	2.901908	0	0	0	0	0	90.01
90.04 09005 ANTI COAGULATION CLINIC	0.612221	0	0	0	0	0	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	0	0	0	0	90.05
91.00 09100 EMERGENCY	0.407417	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	1.503303	0	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	0	0	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)			0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 8:44 am
	Component CCN: 14T046	Title XVII I	Subprovider - IRF

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
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
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
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	0	73.00
76.00 03950 ACUTE DIALYSIS	0	0	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 DIABETES EDUCATION	0	0	90.01
90.04 09005 ANTI COAGULATION CLINIC	0	0	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	90.05
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	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I Date/Time Prepared: 5/29/2015 8:44 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	3,498,006	0	3,498,006	25,711	136.05	30.00	
31.00	INTENSIVE CARE UNIT	1,011,618		1,011,618	3,129	323.30	31.00	
41.00	SUBPROVIDER - IRF	375,524	0	375,524	1,933	194.27	41.00	
43.00	NURSERY	183,697		183,697	1,888	97.30	43.00	
200.00	Total (lines 30-199)	5,068,845		5,068,845	32,661		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	3,475	472,774					30.00
31.00	INTENSIVE CARE UNIT	483	156,154					31.00
41.00	SUBPROVIDER - IRF	148	28,752					41.00
43.00	NURSERY	1,148	111,700					43.00
200.00	Total (lines 30-199)	5,254	769,380					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/29/2015 8:44 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,751,212	71,449,534	0.038506	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	451,530	9,961,383	0.045328	0	0	52.00
53.00	05300	ANESTHESIOLOGY	127,103	9,055,255	0.014036	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,899,147	32,490,066	0.058453	0	0	54.00
57.00	05700	CT SCAN	371,217	38,695,404	0.009593	0	0	57.00
58.00	05800	MRI	149,052	10,062,759	0.014812	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	541,688	30,985,074	0.017482	0	0	59.00
60.00	06000	LABORATORY	849,415	54,037,567	0.015719	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	164,125	1,319,557	0.124379	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	249,965	10,430,506	0.023965	0	0	65.00
66.00	06600	PHYSICAL THERAPY	215,620	6,090,807	0.035401	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,509	2,192,043	0.063643	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	42,375	645,943	0.065602	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	772,142	11,677,175	0.066124	0	0	69.00
70.01	07001	NEUROLOGY	90,078	399,590	0.225426	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	835,879	38,424,694	0.021754	0	0	73.00
76.00	03950	ACUTE DIALYSIS	69,763	1,187,110	0.058767	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	90,200	727,333	0.124015	0	0	90.00
90.01	09001	DIABETES EDUCATION	2,311	17,922	0.128948	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	38,387	436,037	0.088036	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0	0	90.05
91.00	09100	EMERGENCY	1,006,829	21,221,271	0.047444	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	294,551	1,516,577	0.194221	0	0	92.00
200.00		Total (lines 50-199)	11,152,098	353,023,607		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/29/2015 8:44 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
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	25,711	0.00	3,475	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,129	0.00	483	0		31.00
41.00	04100	SUBPROVIDER - IRF	1,933	0.00	148	0		41.00
43.00	04300	NURSERY	1,888	0.00	1,148	0		43.00
200.00		Total (lines 30-199)	32,661		5,254	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
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Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	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
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
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03950	ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
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: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	71,449,534	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	9,961,383	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	9,055,255	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,490,066	0.000000	0.000000	0	54.00
57.00	05700 CT SCAN	0	38,695,404	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	10,062,759	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	30,985,074	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	54,037,567	0.000000	0.000000	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,319,557	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	10,430,506	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	6,090,807	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,192,043	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	645,943	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	11,677,175	0.000000	0.000000	0	69.00
70.01	07001 NEUROLOGY	0	399,590	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	38,424,694	0.000000	0.000000	0	73.00
76.00	03950 ACUTE DIALYSIS	0	1,187,110	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	727,333	0.000000	0.000000	0	90.00
90.01	09001 DIABETES EDUCATION	0	17,922	0.000000	0.000000	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	0	436,037	0.000000	0.000000	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	90.05
91.00	09100 EMERGENCY	0	21,221,271	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	1,516,577	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	353,023,607			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2015 8:44 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		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
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
76.00	03950 ACUTE DIALYSIS	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 DIABETES EDUCATION	0	0	0		90.01
90.04	09005 ANTI COAGULATION CLINIC	0	0	0		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0		90.05
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: 140046 Component CCN: 14T046		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/29/2015 8:44 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,751,212	71,449,534	0.038506	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	451,530	9,961,383	0.045328	0	0 52.00
53.00	05300	ANESTHESIOLOGY	127,103	9,055,255	0.014036	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,899,147	32,490,066	0.058453	0	0 54.00
57.00	05700	CT SCAN	371,217	38,695,404	0.009593	0	0 57.00
58.00	05800	MRI	149,052	10,062,759	0.014812	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	541,688	30,985,074	0.017482	0	0 59.00
60.00	06000	LABORATORY	849,415	54,037,567	0.015719	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	164,125	1,319,557	0.124379	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	249,965	10,430,506	0.023965	0	0 65.00
66.00	06600	PHYSICAL THERAPY	215,620	6,090,807	0.035401	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	139,509	2,192,043	0.063643	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	42,375	645,943	0.065602	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	772,142	11,677,175	0.066124	0	0 69.00
70.01	07001	NEUROLOGY	90,078	399,590	0.225426	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	835,879	38,424,694	0.021754	0	0 73.00
76.00	03950	ACUTE DIALYSIS	69,763	1,187,110	0.058767	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	90,200	727,333	0.124015	0	0 90.00
90.01	09001	DIABETES EDUCATION	2,311	17,922	0.128948	0	0 90.01
90.04	09005	ANTI COAGULATION CLINIC	38,387	436,037	0.088036	0	0 90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0	0 90.05
91.00	09100	EMERGENCY	1,006,829	21,221,271	0.047444	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	1,516,577	0.000000	0	0 92.00
200.00		Total (lines 50-199)	10,857,547	353,023,607		0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	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
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
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 DIABETES EDUCATION	0	0	0	0	0	90.01
90.04	09005 ANTICOAGULATION CLINIC	0	0	0	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
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: 140046 Component CCN: 14T046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
	Title XIX	Subprovider - IRF	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
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	71,449,534	0.000000	0.000000	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	9,961,383	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	9,055,255	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	32,490,066	0.000000	0.000000	0 54.00
57.00 05700 CT SCAN	0	38,695,404	0.000000	0.000000	0 57.00
58.00 05800 MRI	0	10,062,759	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	30,985,074	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	54,037,567	0.000000	0.000000	0 60.00
64.00 06400 INTRAVENOUS THERAPY	0	1,319,557	0.000000	0.000000	0 64.00
65.00 06500 RESPIRATORY THERAPY	0	10,430,506	0.000000	0.000000	0 65.00
66.00 06600 PHYSICAL THERAPY	0	6,090,807	0.000000	0.000000	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	2,192,043	0.000000	0.000000	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	645,943	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	11,677,175	0.000000	0.000000	0 69.00
70.01 07001 NEUROLOGY	0	399,590	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	38,424,694	0.000000	0.000000	0 73.00
76.00 03950 ACUTE DIALYSIS	0	1,187,110	0.000000	0.000000	0 76.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	727,333	0.000000	0.000000	0 90.00
90.01 09001 DIABETES EDUCATION	0	17,922	0.000000	0.000000	0 90.01
90.04 09005 ANTI COAGULATION CLINIC	0	436,037	0.000000	0.000000	0 90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0 90.05
91.00 09100 EMERGENCY	0	21,221,271	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	1,516,577	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	353,023,607			0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/29/2015 8:44 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
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
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
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
76.00	03950	ACUTE DIALYSIS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	90.05
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: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2015 8:44 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		25,711	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		25,711	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)		23,546	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)		13,527	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		27,075,187	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)		27,075,187	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		27,075,187	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,053.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,244,743	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)		14,244,743	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 8:44 am	
Cost Center Description			Title XVIII	Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,567,396	3,129	2,418.47	1,767	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)				25,221,276	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				43,739,455	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)				2,411,619	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				2,621,667	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				5,033,286	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				38,706,169	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)				2,165	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,053.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				2,279,875	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 8:44 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	3,498,006	27,075,187	0.129196	2,279,875	294,551	90.00
91.00	Nursing School cost	0	27,075,187	0.000000	2,279,875	0	91.00
92.00	Allied health cost	0	27,075,187	0.000000	2,279,875	0	92.00
93.00	All other Medical Education	0	27,075,187	0.000000	2,279,875	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 14T046		Date/Time Prepared: 5/29/2015 8:44 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,933	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,933	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)		1,933	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)		1,266	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,471,928	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,471,928	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,471,928	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,278.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,618,961	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)		1,618,961	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
					Component CCN: 14T046		Date/Time Prepared: 5/29/2015 8:44 am
					Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
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)					846,151	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,465,112	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)					245,946	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					85,644	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					331,590	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,133,522	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)					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: 140046 Component CCN: 14T046		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 8:44 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	375,524	2,471,928	0.151915	0	0	90.00
91.00	Nursing School cost	0	2,471,928	0.000000	0	0	91.00
92.00	Allied health cost	0	2,471,928	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,471,928	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 8:44 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		25,711	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		25,711	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)		23,546	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,475	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)		1,888	15.00
16.00	Nursery days (title V or XIX only)		1,148	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		27,075,187	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)		27,075,187	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		27,075,187	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,053.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,659,384	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)		3,659,384	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 8:44 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)	2,304,315	1,888	1,220.51	1,148	1,401,145	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,567,396	3,129	2,418.47	483	1,168,121	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)					6,228,650	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)					740,628	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)					740,628	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,488,022	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)					2,165	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,053.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,279,875	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 8:44 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	3,498,006	27,075,187	0.129196	2,279,875	294,551	90.00
91.00	Nursing School cost	0	27,075,187	0.000000	2,279,875	0	91.00
92.00	Allied health cost	0	27,075,187	0.000000	2,279,875	0	92.00
93.00	All other Medical Education	0	27,075,187	0.000000	2,279,875	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 14T046		Date/Time Prepared: 5/29/2015 8:44 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,933	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,933	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)		1,933	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)		148	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)		1,888	15.00
16.00	Nursery days (title V or XIX only)		1,148	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,471,928	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,471,928	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,471,928	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,278.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		189,262	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)		189,262	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 14T046				Date/Time Prepared: 5/29/2015 8:44 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
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)					189,262	189,262	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)					28,752	28,752	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					28,752	28,752	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					160,510	160,510	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	0	54.00
55.00 Target amount per discharge					0.00	0.00	55.00
56.00 Target amount (line 54 x line 55)					0	0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	0	57.00
58.00 Bonus payment (see instructions)					0	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	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	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	0	61.00
62.00 Relief payment (see instructions)					0	0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	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	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	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	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	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	0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046 Component CCN: 14T046		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/29/2015 8:44 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	375,524	2,471,928	0.151915	0	0	90.00
91.00	Nursing School cost	0	2,471,928	0.000000	0	0	91.00
92.00	Allied health cost	0	2,471,928	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,471,928	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/29/2015 8:44 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		10,543,312	30.00
31.00	03100	INTENSIVE CARE UNIT		2,744,069	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.357498	21,102,794	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.239487	27,364	52.00
53.00	05300	ANESTHESIOLOGY	0.108990	1,654,869	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.250097	4,952,829	54.00
57.00	05700	CT SCAN	0.042372	6,120,266	57.00
58.00	05800	MRI	0.092692	602,096	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.200852	8,689,462	59.00
60.00	06000	LABORATORY	0.178546	16,035,117	60.00
64.00	06400	INTRAVENOUS THERAPY	0.551623	8,243	64.00
65.00	06500	RESPIRATORY THERAPY	0.295736	5,813,807	65.00
66.00	06600	PHYSICAL THERAPY	0.418331	2,278,553	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.498836	550,589	67.00
68.00	06800	SPEECH PATHOLOGY	0.862876	142,563	68.00
69.00	06900	ELECTROCARDIOLOGY	0.276291	3,454,997	69.00
70.01	07001	NEUROLOGY	0.728935	116,469	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.364766	14,475,020	73.00
76.00	03950	ACUTE DIALYSIS	0.868631	865,643	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.842173	0	90.00
90.01	09001	DIABETES EDUCATION	2.901908	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0.612221	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	90.05
91.00	09100	EMERGENCY	0.407417	2,900,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.503303	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		89,791,559	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)		89,791,559	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/29/2015 8:44 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		853,510		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.357498	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.239487	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.108990	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.250097	15,833	3,960	54.00
57.00	05700 CT SCAN	0.042372	8,196	347	57.00
58.00	05800 MRI	0.092692	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.200852	0	0	59.00
60.00	06000 LABORATORY	0.178546	133,025	23,751	60.00
64.00	06400 INTRAVENOUS THERAPY	0.551623	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.295736	63,969	18,918	65.00
66.00	06600 PHYSICAL THERAPY	0.418331	750,227	313,843	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.498836	715,573	356,954	67.00
68.00	06800 SPEECH PATHOLOGY	0.862876	68,858	59,416	68.00
69.00	06900 ELECTROCARDIOLOGY	0.276291	4,562	1,260	69.00
70.01	07001 NEUROLOGY	0.728935	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.364766	165,085	60,217	73.00
76.00	03950 ACUTE DIALYSIS	0.868631	8,617	7,485	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.842173	0	0	90.00
90.01	09001 DIABETES EDUCATION	2.901908	0	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	0.612221	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	0	90.05
91.00	09100 EMERGENCY	0.407417	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	1.503303	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,933,945	846,151	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,933,945		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 8:44 am
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		20,321,250	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,979,566	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		1,506,638	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		2,290,948	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		111.09	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.47	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.09	31.00
32.00	Sum of lines 30 and 31		28.56	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.78	33.00
34.00	Disproportionate share adjustment (see instructions)		872,261	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 8:44 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000132255	0.000143513	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,196,425	1,097,533	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		894,860	276,639	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,171,499		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		30,851,214		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		30,851,214		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,323,891		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		3,411		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)		33,178,516		59.00
60.00	Primary payer payments		12,136		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		33,166,380		61.00
62.00	Deductibles billed to program beneficiaries		2,711,778		62.00
63.00	Coinurance billed to program beneficiaries		82,680		63.00
64.00	Allowable bad debts (see instructions)		274,471		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		178,406		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		178,406		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		30,550,328		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)		65,603		70.93
70.94	HRR adjustment amount (see instructions)		-278,969		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 8:44 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)		30,336,962		71.00
71.01	Sequestration adjustment (see instructions)		606,739		71.01
72.00	Interim payments		29,706,990		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)		23,233		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)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140046

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2015 8:44 am

		Title XVIII		Hospital		PPS		
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	20,321,250	0	20,321,250	0	20,321,250	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,979,566	0	0	6,979,566	6,979,566	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,506,638	0	1,070,046	436,592	1,506,638	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,290,948	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1278	0.1278	0.1278	0.1278		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	872,261	0	649,264	222,997	872,261	11.00
11.01	Uncompensated care payments	36.00	1,171,499	0	894,860	276,639	1,171,499	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	30,851,214	0	22,935,420	7,915,794	30,851,214	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	30,851,214	0	22,935,420	7,915,794	30,851,214	15.00
16.00	Payment for inpatient program capital	50.00	2,323,891	0	1,677,864	646,027	2,323,891	16.00
17.00	Special add-on payments for new technologies	54.00	3,411	0	1,705	1,705	3,410	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140046

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2015 8:44 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
19.00	SUBTOTAL		0	24,614,989	8,563,526	33,178,515	19.00	
	W/S L, line	(Amounts from L)						
	0	1.00	2.00	3.00	4.00	5.00		
20.00	Capital DRG other than outlier	1.00	2,168,318	0	1,613,666	554,651	2,168,317	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	155,573	0	64,197	91,376	155,573	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,323,891	0	1,677,864	646,027	2,323,891	26.00
	W/S E, Part A line	(Amounts to E, Part A)						
	0	1.00	2.00	3.00	4.00	5.00		
27.00	Low volume adjustment factor			0.000000	0.000000			27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96		0			0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2015 8:44 am
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		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	20,321,250	20,321,250		20,321,250	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,979,566		6,979,566	6,979,566	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,506,638	1,070,046	436,592	1,506,638	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	2,290,948	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1278	0.1278	0.1278		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	872,261	649,264	222,997	872,261	11.00
11.01	Uncompensated care payments	36.00	1,171,499	894,860	276,639	1,171,499	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	30,851,214	22,935,420	7,915,794	30,851,214	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	30,851,214	22,935,420	7,915,794	30,851,214	15.00
16.00	Payment for inpatient program capital	50.00	2,323,891	1,677,864	646,027	2,323,891	16.00
17.00	Special add-on payments for new technologies	54.00	3,411	1,706	1,705	3,411	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			24,614,990	8,563,526	33,178,516	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2015 8:44 am
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,168,318	1,613,667	554,651	2,168,318	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	155,573	64,197	91,376	155,573	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,323,891	1,677,864	646,027	2,323,891	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.90 plus 70.93	65,603	59,300	6,303	65,603	30.00
31.00	HRR adjustment (see instructions)	70.91 plus 70.94	-278,969	-237,779	-41,190	-278,969	31.00
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 8:44 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		61,633	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		16,039,895	2.00
3.00	PPS payments		10,274,573	3.00
4.00	Outlier payment (see instructions)		68,930	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)		61,633	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		187,953	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)		187,953	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		187,953	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		126,320	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)		61,633	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)		10,343,503	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		2,141,281	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)		8,263,855	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)		8,263,855	30.00
31.00	Primary payer payments		76	31.00
32.00	Subtotal (line 30 minus line 31)		8,263,779	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		167,357	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		108,782	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		108,782	36.00
37.00	Subtotal (see instructions)		8,372,561	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)		8,372,561	40.00
40.01	Sequestration adjustment (see instructions)		167,451	40.01
41.00	Interim payments		8,078,965	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		126,145	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 8:44 am
		Title XVII I	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)			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)			0 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)			0 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			0 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			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)			0 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)			0 40.00
40.01	Sequestration adjustment (see instructions)			0 40.01
41.00	Interim payments			0 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140046

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2015 8:44 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		29,706,990		8,078,965	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)		29,706,990		8,078,965	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		23,233		126,145	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		29,730,223		8,205,110	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: 140046
Component CCN: 14T046

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2015 8:44 am
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,290,937		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,290,937		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		28,218		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,319,155		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/29/2015 8:44 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			6,728 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			15,294 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,327 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			26,675 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			382,152,310 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6,271,610 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)			1,480,394 8.00
9.00	Sequestration adjustment amount (see instructions)			29,608 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,450,786 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,467,881 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)			-17,095 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/29/2015 8:44 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,191,442 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0287 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			70,564 3.00
4.00	Outlier Payments			112,505 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			5.295890 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,374,511 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,374,511 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,374,511 19.00
20.00	Deductibles			8,512 20.00
21.00	Subtotal (line 19 minus line 20)			2,365,999 21.00
22.00	Coinsurance			304 22.00
23.00	Subtotal (line 21 minus line 22)			2,365,695 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,216 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			790 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			790 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,366,485 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,366,485 32.00
32.01	Sequestration adjustment (see instructions)			47,330 32.01
33.00	Interim payments			2,290,937 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34			28,218 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			112,505 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: 140046

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

Worksheet G

Date/Time Prepared:
5/29/2015 8:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-5,021,093	0	0	0	1.00
2.00	Temporary investments	274,218	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	26,457,522	0	0	0	4.00
5.00	Other receivable	1,486,500	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,382,964	0	0	0	6.00
7.00	Inventory	3,667,407	0	0	0	7.00
8.00	Prepaid expenses	1,507,264	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,988,854	0	0	0	11.00
FIXED ASSETS						
12.00	Land	632,759	0	0	0	12.00
13.00	Land improvements	6,613,257	0	0	0	13.00
14.00	Accumulated depreciation	-2,049,751	0	0	0	14.00
15.00	Buildings	156,279,950	0	0	0	15.00
16.00	Accumulated depreciation	-12,930,119	0	0	0	16.00
17.00	Leasehold improvements	17,268,982	0	0	0	17.00
18.00	Accumulated depreciation	-1,763,632	0	0	0	18.00
19.00	Fixed equipment	13,770,680	0	0	0	19.00
20.00	Accumulated depreciation	-2,153,690	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	57,139,558	0	0	0	23.00
24.00	Accumulated depreciation	-27,018,870	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)	205,789,124	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,428,609	718,099	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,428,609	718,099	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	237,206,587	718,099	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,354,577	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)	5,188,110	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,580,946	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,123,633	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	136,010,877	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,967,404	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	147,978,281	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	162,101,914	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	75,104,673				52.00
53.00	Specific purpose fund		718,099			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	75,104,673	718,099	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	237,206,587	718,099	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140046

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

Worksheet G-1

Date/Time Prepared:
5/29/2015 8:44 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		82,362,652		773,265	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-5,434,346			2.00
3.00	Total (sum of line 1 and line 2)		76,928,306		773,265	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		76,928,306		773,265	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	CORPORATE OFFICE	0		55,166		13.00
14.00	TRANSFER TO RELATED	8,661,307		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		8,661,307		55,166	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		68,266,999		718,099	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	CORPORATE OFFICE		0			13.00
14.00	TRANSFER TO RELATED		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: 140046

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2015 8:44 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	23,186,561		23,186,561	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,308,501		1,308,501	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)	24,495,062		24,495,062	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,933,855		4,933,855	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)	4,933,855		4,933,855	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	29,428,917		29,428,917	17.00
18.00	Ancillary services	168,784,520	168,713,760	337,498,280	18.00
19.00	Outpatient services	5,223,759	19,102,323	24,326,082	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)	203,437,196	187,816,083	391,253,279	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		146,296,559		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)		146,296,559		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140046

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

Worksheet G-3

Date/Time Prepared:
5/29/2015 8:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	391,253,279	1.00
2.00	Less contractual allowances and discounts on patients' accounts	258,732,267	2.00
3.00	Net patient revenues (line 1 minus line 2)	132,521,012	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	146,296,559	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-13,775,547	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	6,521	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	318,477	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	10,769	21.00
22.00	Rental of hospital space	254,582	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - DONATIONS	-133,796	24.00
24.01	OTHER	7,917,910	24.01
25.00	Total other income (sum of lines 6-24)	8,374,463	25.00
26.00	Total (line 5 plus line 25)	-5,401,084	26.00
27.00	OTHER	33,262	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	33,262	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-5,434,346	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140046	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/29/2015 8:44 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,168,318	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		155,573	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)		75.10	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)		2,323,891	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00