

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: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet S Parts I-III Date/Time Prepared: 5/14/2015 10:28 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/14/2015 Time: 10:28 am	
	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.		
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 VISTA MEDICAL CENTER - EAST (140084) for the cost reporting period beginning 12/01/2013 and ending 11/30/2014 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 XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	683,084	-127,383	-133,601	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
200.00 Total	0	683,084	-127,383	-133,601	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: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet S-2 Part I Date/Time Prepared: 5/11/2015 7:37 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1324 NORTH SHERIDAN ROAD		PO Box:						1.00		
2.00	City: WAUKEGAN		State: IL		Zip Code: 60085-		County: LAKE		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		VISTA MEDICAL CENTER - EAST	140084	29404	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					12/01/2013	11/30/2014		20.00		
21.00	Type of Control (see instructions)					4			21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3		N	23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	7,772	4,005	11	32	2,954	199		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part I Date/Time Prepared: 5/11/2015 7:37 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00		
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	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.					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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
			Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00

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		V	XIX				
		1.00	2.00				
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00		
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00		
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00		
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
		1.00	2.00	3.00			
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00		
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	1			118.00		
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	164,821	541,381		118.01		
		1.00	2.00				
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02		
119.00	DO NOT USE THIS LINE			119.00			
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00		
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00			
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part I Date/Time Prepared: 5/11/2015 7:37 am	
		1.00	2.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS		Contractor's Number: 52280	
142.00	Street: 4000 MERIDIAN BLVD	PO Box:			
143.00	City: FRANKLIN	State: TN		Zip Code: 37067	
				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.			Y	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		N	N	N
				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
		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)				0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.50

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet S-2 Part I Date/Time Prepared: 5/11/2015 7:37 am	
			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: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet S-2 Part II Date/Time Prepared: 5/11/2015 7:37 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			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.					Y	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)			Y	03/27/2015	Y	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)			N		N	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: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-2
Part II
Date/Time Prepared:
5/11/2015 7:37 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.	1.00 N	2.00	3.00 N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	12/31/2013
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JENNI FER	RAY		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7390	JENNI FER_RAY2@CHS.NET		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)	03/27/2015		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)			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.	REVENUE MANAGER		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: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/11/2015 7:37 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	167	60,955	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)		167	60,955	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	23	8,395	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)		190	69,350	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		190				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: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/11/2015 7:37 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)	17,235	6,326	38,199			1.00
2.00 HMO and other (see instructions)	1,343	5,802				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)	17,235	6,326	38,199			7.00
8.00 INTENSIVE CARE UNIT	3,157	211	5,950			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		2,435	3,386			13.00
14.00 Total (see instructions)	20,392	8,972	47,535	0.00	812.54	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	812.54	27.00
28.00 Observation Bed Days		0	1,788			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	199	315			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: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
5/11/2015 7:37 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	4,033	3,121	11,121	1.00
2.00 HMO and other (see instructions)			297	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	4,033	3,121	11,121	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					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: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet S-3 Part II Date/Time Prepared: 5/11/2015 7:37 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	52,808,189	0	52,808,189	1,674,911.00	31.53	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		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)		354,113	567,603	921,716	26,185.00	35.20	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		226,590	0	226,590	3,469.30	65.31	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		206,328	0	206,328	1,701.44	121.27	13.00
14.00	Home office salaries & wage-related costs		3,811,792	0	3,811,792	59,199.00	64.39	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)		10,950,178	0	10,950,178			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		186,336	0	186,336			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	372,819	0	372,819	8,200.00	45.47	26.00
27.00	Administrative & General	5.00	6,625,266	-567,980	6,057,286	226,806.32	26.71	27.00
28.00	Administrative & General under contract (see inst.)		1,111,843	0	1,111,843	46,913.50	23.70	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	859,161	0	859,161	33,956.00	25.30	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,390,827	0	1,390,827	87,241.00	15.94	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,325,476	0	1,325,476	70,390.00	18.83	35.00
36.00	Cafeteria	11.00	0	0	0	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	2,901,083	0	2,901,083	61,922.00	46.85	38.00
39.00	Central Services and Supply	14.00	391,467	0	391,467	27,407.00	14.28	39.00
40.00	Pharmacy	15.00	1,627,829	0	1,627,829	45,431.00	35.83	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-3
Part II
Date/Time Prepared:
5/11/2015 7:37 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	16.00 921,029	0	921,029	40,626.00	22.67	41.00
42.00	Social Service	17.00 4,044	0	4,044	302.00	13.39	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet S-3
Part III
Date/Time Prepared:
5/11/2015 7:37 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	56,636,335	0	56,636,335	1,879,455.50	30.13	1.00
2.00	Excluded area salaries (see instructions)	354,113	567,603	921,716	26,185.00	35.20	2.00
3.00	Subtotal salaries (line 1 minus line 2)	56,282,222	-567,603	55,714,619	1,853,270.50	30.06	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,244,710	0	4,244,710	64,369.74	65.94	4.00
5.00	Subtotal wage-related costs (see inst.)	10,950,178	0	10,950,178	0.00	19.65	5.00
6.00	Total (sum of lines 3 thru 5)	71,477,110	-567,603	70,909,507	1,917,640.24	36.98	6.00
7.00	Total overhead cost (see instructions)	17,530,844	-567,980	16,962,864	649,194.82	26.13	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/11/2015 7:37 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,085,660 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 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)			5,205,709 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			83,190 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			44,490 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			-480 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			185,259 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			375,909 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			3,084,154 17.00
18.00	Medicare Taxes - Employers Portion Only			721,294 18.00
19.00	Unemployment Insurance			293,063 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			58,266 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			11,136,514 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet S-3 Part V Date/Time Prepared: 5/11/2015 7:37 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		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital -Based SNF			8.00
9.00	Hospital -Based NF			9.00
10.00	Hospital -Based OLTC			10.00
11.00	Hospital -Based HHA		0	0 11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital -Based Hospice		0	0 13.00
14.00	Hospital -Based Health Clinic RHC		0	0 14.00
15.00	Hospital -Based Health Clinic FQHC			15.00
16.00	Hospital -Based-CMHC			16.00
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet S-10 Date/Time Prepared: 5/11/2015 7:37 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)		0.116224		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		27,076,899		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		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		0		5.00
6.00	Medicaid charges		296,093,176		6.00
7.00	Medicaid cost (line 1 times line 6)		34,413,133		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)		7,336,234		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		12,625		9.00
10.00	Stand-alone SCHIP charges		13,632		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		1,584		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)		7,336,234		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	17,835,924	185,756	18,021,680	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,072,962	21,589	2,094,551	21.00
22.00	Partial payment by patients approved for charity care	19,982	18,391	38,373	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,052,980	3,198	2,056,178	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		Y		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		2,691		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		21,572,432		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,207,888		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		20,364,544		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,366,849		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,423,027		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		11,759,261		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet A Date/Time Prepared: 5/11/2015 7:37 am		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,942,114		644,988	3,587,102	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		7,390,898		2,651,250	10,042,148	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	372,819	402,231	775,050	6,986,741	7,761,791	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,625,266	83,778,618	90,403,884	-9,511,550	80,892,334	5.00
7.00	00700	OPERATION OF PLANT	859,161	4,092,878	4,952,039	-5,565	4,946,474	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,073,507	1,073,507	0	1,073,507	8.00
9.00	00900	HOUSEKEEPING	0	2,327,865	2,327,865	0	2,327,865	9.00
10.00	01000	DIETARY	0	2,931,572	2,931,572	-8,197	2,923,375	10.00
11.00	01100	CAFETERIA	0	0	0	8,197	8,197	11.00
13.00	01300	NURSING ADMINISTRATION	2,901,083	428,977	3,330,060	-3,796	3,326,264	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	391,467	8,671,008	9,062,475	-7,863,168	1,199,307	14.00
15.00	01500	PHARMACY	1,627,829	6,090,843	7,718,672	-5,761,849	1,956,823	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	921,029	1,765,923	2,686,952	-3,614	2,683,338	16.00
17.00	01700	SOCIAL SERVICE	4,044	1,176	5,220	0	5,220	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,289,723	2,979,767	13,269,490	479,682	13,749,172	30.00
31.00	03100	INTENSIVE CARE UNIT	3,628,010	828,129	4,456,139	-3,795	4,452,344	31.00
40.00	04000	SUBPROVIDER - I/PF	0	4,500	4,500	-4,500	0	40.00
41.00	04100	SUBPROVIDER - I/RF	377	0	377	-377	0	41.00
43.00	04300	NURSERY	992,487	159,505	1,151,992	171,140	1,323,132	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,864,547	3,963,013	6,827,560	-519,221	6,308,339	50.00
51.00	05100	RECOVERY ROOM	1,621,942	146,091	1,768,033	-1,128	1,766,905	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,775,849	502,006	2,277,855	-661,862	1,615,993	52.00
53.00	05300	ANESTHESIOLOGY	37,153	1,355,459	1,392,612	0	1,392,612	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,500,563	3,213,183	6,713,746	1,445,330	8,159,076	54.00
54.01	05401	ULTRASOUND	403,875	94,624	498,499	-498,499	0	54.01
56.00	05600	RADIOISOTOPE	263,406	434,155	697,561	-697,561	0	56.00
57.00	05700	CT SCAN	492,992	294,130	787,122	-787,122	0	57.00
58.00	05800	MRI	185,528	168,244	353,772	-353,772	0	58.00
60.00	06000	LABORATORY	3,178,519	4,341,826	7,520,345	-151,944	7,368,401	60.00
65.00	06500	RESPIRATORY THERAPY	788,712	420,531	1,209,243	-170,275	1,038,968	65.00
66.00	06600	PHYSICAL THERAPY	1,937,847	457,818	2,395,665	265,205	2,660,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	287,447	22,025	309,472	-309,472	0	67.00
68.00	06800	SPEECH PATHOLOGY	142,011	11,801	153,812	-153,812	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,636,676	929,665	2,566,341	-28,673	2,537,668	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,210,412	2,210,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,274,434	5,274,434	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,610,699	5,610,699	73.00
74.00	07400	RENAL DIALYSIS	0	558,877	558,877	0	558,877	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.02	03951	GUIDANCE	195,086	33,585	228,671	-50	228,621	76.02
76.03	03952	WOUND CARE	417,558	621,456	1,039,014	-1,039,014	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	4,111,447	2,424,542	6,535,989	1,029,874	7,565,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	298,252	268,043	566,295	-1,595	564,700	95.00
101.00	10100	HOME HEALTH AGENCY	0	12	12	-12	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	7,844	678	8,522	-8,522	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,760,549	146,131,275	198,891,824	-1,770,993	197,120,831	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,280	4,280	64,987	69,267	192.00
192.01	19201	CHIROPRACTIC WORKS LESSEE	0	0	0	0	0	192.01
194.00	07950	CLINIC CORPORATION	0	0	0	0	0	194.00
194.01	07951	SENIOR CIRCLE	47,640	65,925	113,565	0	113,565	194.01
194.02	07952	MARKETING	0	0	0	1,566,574	1,566,574	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	139,432	139,432	194.03
194.04	07954	ABBOTT RESEARCH	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	52,808,189	146,201,480	199,009,669	0	199,009,669	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A
Date/Time Prepared:
5/11/2015 7:37 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	1,195,226	4,782,328	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,281,457	6,760,691	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-13,394	7,748,397	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-59,908,606	20,983,728	5.00
7.00	00700	OPERATION OF PLANT	-260,161	4,686,313	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-98	1,073,409	8.00
9.00	00900	HOUSEKEEPING	-730,340	1,597,525	9.00
10.00	01000	DIETARY	-4,572	2,918,803	10.00
11.00	01100	CAFETERIA	0	8,197	11.00
13.00	01300	NURSING ADMINISTRATION	-25,897	3,300,367	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,199,307	14.00
15.00	01500	PHARMACY	0	1,956,823	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-15,728	2,667,610	16.00
17.00	01700	SOCIAL SERVICE	0	5,220	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,271,327	12,477,845	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,452,344	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
43.00	04300	NURSERY	0	1,323,132	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-563,837	5,744,502	50.00
51.00	05100	RECOVERY ROOM	-1,795	1,765,110	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,615,993	52.00
53.00	05300	ANESTHESIOLOGY	-1,125,115	267,497	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-31,639	8,127,437	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	7,368,401	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,038,968	65.00
66.00	06600	PHYSICAL THERAPY	0	2,660,870	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-194,725	2,342,943	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,210,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,274,434	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-5,527	5,605,172	73.00
74.00	07400	RENAL DIALYSIS	0	558,877	74.00
76.00	03020	CARDIAC REHAB	0	0	76.00
76.02	03951	GUI DANCE	0	228,621	76.02
76.03	03952	WOUND CARE	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	-1,147,539	6,418,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-384,552	180,148	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-67,771,083	129,349,748	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	69,267	192.00
192.01	19201	CHIROPRACTIC WORKS LESSEE	0	0	192.01
194.00	07950	CLINIC CORPORATION	0	0	194.00
194.01	07951	SENIOR CIRCLE	0	113,565	194.01
194.02	07952	MARKETING	0	1,566,574	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	139,432	194.03
194.04	07954	ABBOTT RESEARCH	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-67,771,083	131,238,586	200.00

RECLASSIFICATIONS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-6
Date/Time Prepared:
5/11/2015 7:37 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,989,710	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	6,989,710	
B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	62,608	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	62,608	
C - RECLASS LEASE AND RENTAL EXP					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,637,562	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	TOTALS		0	2,637,562	
D - RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	485,113	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	159,875	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,688	3.00
	TOTALS		0	658,676	
E - RECLASS MARKETING DEPT					
1.00	MARKETING	194.02	372,095	1,194,479	1.00
	TOTALS		372,095	1,194,479	
F - RECLASS COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,610,699	1.00
	TOTALS		0	5,610,699	
G - RECLASS LABOR & DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	452,789	33,631	1.00
2.00	NURSERY	43.00	50,159	123,218	2.00
	TOTALS		502,948	156,849	
H - RECLASS PT, OT AND SP COSTS					
1.00	PHYSICAL THERAPY	66.00	429,458	33,826	1.00
2.00		0.00	0	0	2.00
	TOTALS		429,458	33,826	
I - RECLASS MISC DEPTS					
1.00	ADULTS & PEDIATRICS	30.00	377	4,500	1.00
2.00	EMERGENCY	91.00	417,558	620,328	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	7,844	690	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		425,779	625,518	
J - RECLASS OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,345,801	991,153	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		1,345,801	991,153	
K - RECLASS PORTION OF DIETARY COSTS					
1.00	CAFETERIA	11.00	0	8,197	1.00
	TOTALS		0	8,197	
L - ALLOCATION TO VISTA WEST					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	56,453	0	1.00
2.00	VISTA MEDICAL CENTER WEST	194.03	139,432	0	2.00
	TOTALS		195,885	0	

RECLASSIFICATIONS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-6

Date/Time Prepared:
5/11/2015 7:37 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	M - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,147,804	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,274,434	2.00
3.00	OPERATING ROOM	50.00	0	356,811	3.00
	TOTALS		0	7,779,049	
500.00	Grand Total: Increases		3,271,966	26,748,326	500.00

RECLASSIFICATIONS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-6
Date/Time Prepared:
5/11/2015 7:37 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - RECLASS EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,988,430	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	1,280	0	2.00
	TOTALS		0	6,989,710		
B - RECLASS OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	844	0	1.00
2.00	OPERATING ROOM	50.00	0	1,657	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	59,293	0	3.00
4.00	EMERGENCY	91.00	0	814	0	4.00
	TOTALS		0	62,608		
C - RECLASS LEASE AND RENTAL EXP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,969	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	101,985	0	2.00
3.00	OPERATION OF PLANT	7.00	0	5,565	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	2,516	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	84,850	0	5.00
6.00	PHARMACY	15.00	0	151,150	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,614	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	11,615	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	3,795	0	9.00
10.00	NURSERY	43.00	0	2,237	0	10.00
11.00	OPERATING ROOM	50.00	0	874,375	0	11.00
12.00	RECOVERY ROOM	51.00	0	1,128	0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,065	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	891,624	0	14.00
15.00	LABORATORY	60.00	0	151,944	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	110,982	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	198,079	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	27,098	0	18.00
19.00	WOUND CARE	76.03	0	1,128	0	19.00
20.00	EMERGENCY	91.00	0	7,198	0	20.00
21.00	AMBULANCE SERVICES	95.00	0	1,595	0	21.00
22.00	GUI DANCE	76.02	0	50	0	22.00
	TOTALS		0	2,637,562		
D - RECLASS OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	658,676	13	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	12	3.00
	TOTALS		0	658,676		
E - RECLASS MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	372,095	1,194,479	0	1.00
	TOTALS		372,095	1,194,479		
F - RECLASS COST OF DRUGS						
1.00	PHARMACY	15.00	0	5,610,699	0	1.00
	TOTALS		0	5,610,699		
G - RECLASS LABOR & DELIVERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	502,948	156,849	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		502,948	156,849		
H - RECLASS PT, OT AND SP COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	287,447	22,025	0	1.00
2.00	SPEECH PATHOLOGY	68.00	142,011	11,801	0	2.00
	TOTALS		429,458	33,826		
I - RECLASS MISC DEPTS						
1.00	SUBPROVIDER - IPF	40.00	0	4,500	0	1.00
2.00	WOUND CARE	76.03	417,558	620,328	0	2.00
3.00	SUBPROVIDER - IRF	41.00	377	0	0	3.00
4.00	HOME HEALTH AGENCY	101.00	0	12	0	4.00
5.00	HOSPICE	116.00	7,844	678	0	5.00
	TOTALS		425,779	625,518		
J - RECLASS OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	403,875	94,624	0	1.00
2.00	RADIOISOTOPE	56.00	263,406	434,155	0	2.00
3.00	CT SCAN	57.00	492,992	294,130	0	3.00
4.00	MRI	58.00	185,528	168,244	0	4.00
	TOTALS		1,345,801	991,153		
K - RECLASS PORTION OF DIETARY COSTS						
1.00	DIETARY	10.00	0	8,197	0	1.00
	TOTALS		0	8,197		
L - ALLOCATION TO VISTA WEST						
1.00	ADMINISTRATIVE & GENERAL	5.00	195,885	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		195,885	0		

RECLASSIFICATIONS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-6

Date/Time Prepared:
5/11/2015 7:37 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
M - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,777,474	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	0	1,575	0	2.00
3.00		0.00	0	0	0	3.00
TOTALS			0	7,779,049		
500.00	Grand Total: Decreases		3,271,966	26,748,326		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
5/11/2015 7:37 am

	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	67,659	0	0	0	1.00
2.00	Land Improvements	4,044,718	46,120	0	46,120	2.00
3.00	Buildings and Fixtures	89,852,954	13,347	0	13,347	3.00
4.00	Building Improvements	22,822,882	211,908	0	211,908	4.00
5.00	Fixed Equipment	7,173,858	29,344	0	29,344	5.00
6.00	Movable Equipment	87,051,604	1,051,258	0	1,051,258	6.00
7.00	HIT designated Assets	4,433,104	13,848,527	0	13,848,527	7.00
8.00	Subtotal (sum of lines 1-7)	215,446,779	15,200,504	0	15,200,504	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	215,446,779	15,200,504	0	15,200,504	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	67,659	0			1.00
2.00	Land Improvements	4,090,838	0			2.00
3.00	Buildings and Fixtures	89,866,301	0			3.00
4.00	Building Improvements	23,034,790	0			4.00
5.00	Fixed Equipment	7,203,202	0			5.00
6.00	Movable Equipment	85,976,012	0			6.00
7.00	HIT designated Assets	18,280,517	0			7.00
8.00	Subtotal (sum of lines 1-7)	228,519,319	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	228,519,319	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,942,114	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,390,898	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,333,012	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,942,114				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,390,898				2.00
3.00	Total (sum of lines 1-2)	0	10,333,012				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-7
Part III
Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	117,059,588	0	117,059,588	0.512252	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	111,459,732	0	111,459,732	0.487748	0	2.00
3.00	Total (sum of lines 1-2)	228,519,320	0	228,519,320	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	3,465,510	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,427,042	2,319,961	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,892,552	2,319,961	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	671,830	159,875	485,113	0	4,782,328	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,688	0	0	6,760,691	2.00
3.00	Total (sum of lines 1-2)	671,830	173,563	485,113	0	11,543,019	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-8

Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			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)	B	-120,928		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-4,791,406				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-16,845,258				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-4,572		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	-5,527		DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-15,728		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	-930		ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	461,360		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-3,442,830		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 INSERVICE EDUCATION REVENUE	B	-10,487		NURSING ADMINISTRATION	13.00	0	33.00
34.00 FITNESS REVENUE	B	-63,858		ADMINISTRATIVE & GENERAL	5.00	0	34.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
35.00 CARELINE REVENUE	B	-32,331	ADMINISTRATIVE & GENERAL	5.00	0 35.00
36.00 RENTAL INCOME	B	-43,396	CAP REL COSTS-BLDG & FIXT	1.00	9 36.00
37.00 OTHER MISC REVENUE	B	74,247	ADMINISTRATIVE & GENERAL	5.00	0 37.00
38.00 ORG COST AMORTIZATION	A	-10,546	ADMINISTRATIVE & GENERAL	5.00	0 38.00
39.00 BAD DEBTS	A	-34,110,714	ADMINISTRATIVE & GENERAL	5.00	0 39.00
40.00 NON-ALLOWABLE PHONE / TV	A	-63,514	ADMINISTRATIVE & GENERAL	5.00	0 40.00
40.01 NON-ALLOWABLE PHONE / TV	A	-126,636	ADMINISTRATIVE & GENERAL	5.00	0 40.01
40.02 NON-ALLOWABLE PHONE / TV	A	-14,081	ADMINISTRATIVE & GENERAL	5.00	0 40.02
40.03 NON-ALLOWABLE PHONE / TV	A	-18,928	CAP REL COSTS-MVBLE EQUIP	2.00	9 40.03
40.04 NON-ALLOWABLE PHONE / TV	A	-13,394	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 40.04
40.05 NON-ALLOWABLE PHONE / TV	A	-1,910	CAP REL COSTS-MVBLE EQUIP	2.00	9 40.05
DEPREC					
41.00 PHYSICIAN RECRUITING	A	-171,838	ADMINISTRATIVE & GENERAL	5.00	0 41.00
42.00 STATE OPERATING TAX	A	-7,321,078	ADMINISTRATIVE & GENERAL	5.00	0 42.00
43.00 CLUB DUES AND LOBBYING	A	-79,418	ADMINISTRATIVE & GENERAL	5.00	0 43.00
44.00 LEGAL FEES	A	-52,364	ADMINISTRATIVE & GENERAL	5.00	0 44.00
44.01 LATE FEES	A	-786	ADMINISTRATIVE & GENERAL	5.00	0 44.01
44.02		0		0.00	0 44.02
44.03 PENALTIES	A	3,307	ADMINISTRATIVE & GENERAL	5.00	0 44.03
44.04 AMBULANCE TRAINING	B	-384,552	AMBULANCE SERVICES	95.00	0 44.04
45.01 ALLOCATED SECURITY / PLANT OPS	A	-260,161	OPERATION OF PLANT	7.00	0 45.01
45.02 ALLOCATED HOUSEKEEPING	A	-730,340	HOUSEKEEPING	9.00	0 45.02
45.03 ALLOCATED LAUNDRY & LINEN	A	-98	LAUNDRY & LINEN SERVICE	8.00	0 45.03
45.04 ALLOCATED RECOVERY ROOM	A	-1,795	RECOVERY ROOM	51.00	0 45.04
45.05 ALLOCATED ANESTHESIA	A	-115	ANESTHESIOLOGY	53.00	0 45.05
45.06 ALLOCATED EKG	A	-15,658	ELECTROCARDIOLOGY	69.00	0 45.06
45.07 ALLOCATED BUSINESS OFFICE FROM WEST	A	445,180	ADMINISTRATIVE & GENERAL	5.00	0 45.07
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-67,771,083			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: 140084

Period: From 12/01/2013 To 11/30/2014

Worksheet A-8-1

Date/Time Prepared: 5/11/2015 7:37 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	DIRECT CAPITAL RELATED INTER	671,830	0
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	828,747	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	45,906	0
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL BUILDING & FIXTU	59,526	0
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL MOVABLE EQUIPMEN	476,847	0
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	3,623,923	16,424,437
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	706,202	6,539,166
4.04	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	315,011	632,612
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	22,965	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,750,957	23,596,215

* 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	COMMUNITY HEALTH SYSTEMS	100.00	6.00
7.00	B	0.00	PASI	100.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-8-1

Date/Time Prepared:
5/11/2015 7:37 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	671,830	11		1.00
2.00	828,747	0		2.00
3.00	45,906	9		3.00
4.00	59,526	9		4.00
4.01	476,847	9		4.01
4.02	-12,800,514	0		4.02
4.03	-5,832,964	0		4.03
4.04	-317,601	10		4.04
4.05	22,965	9		4.05
5.00	-16,845,258			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	COLLECTION AGENCY		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: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet A-8-2

Date/Time Prepared:
5/11/2015 7:37 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	457,587	457,587	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	49,913	0	49,913	177,200	405	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,271,327	1,271,327	0	0	0	3.00
4.00	50.00	OPERATING ROOM	563,837	563,837	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,125,000	1,125,000	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	31,639	31,639	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	179,067	179,067	0	0	0	7.00
8.00	91.00	EMERGENCY	1,147,539	1,147,539	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,825,909	4,775,996	49,913		405	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	34,503	1,725	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			34,503	1,725	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	457,587	1.00
2.00	13.00	NURSING ADMINISTRATION	0	34,503	15,410	15,410	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,271,327	3.00
4.00	50.00	OPERATING ROOM	0	0	0	563,837	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,125,000	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	31,639	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	179,067	7.00
8.00	91.00	EMERGENCY	0	0	0	1,147,539	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	34,503	15,410	4,791,406	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet B
Part I
Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,782,328	4,782,328			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	6,760,691		6,760,691		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	7,748,397	73,556	109,175	7,931,128	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,983,728	555,788	824,920	916,195	5.00
7.00 00700	OPERATION OF PLANT	4,686,313	1,347,528	2,000,046	129,952	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,073,409	82,444	122,366	0	8.00
9.00 00900	HOUSEKEEPING	1,597,525	45,086	66,919	0	9.00
10.00 01000	DIETARY	2,918,803	145,944	216,616	0	10.00
11.00 01100	CAFETERIA	8,197	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	3,300,367	24,748	36,732	438,803	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,199,307	112,230	166,576	59,211	14.00
15.00 01500	PHARMACY	1,956,823	33,007	48,990	246,217	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,667,610	52,432	77,822	139,310	16.00
17.00 01700	SOCIAL SERVICE	5,220	4,301	6,384	612	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	12,477,845	755,707	1,121,646	1,624,931	30.00
31.00 03100	INTENSIVE CARE UNIT	4,452,344	135,161	200,611	548,755	31.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00 04300	NURSERY	1,323,132	24,699	36,659	157,705	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,744,502	264,843	393,089	433,277	50.00
51.00 05100	RECOVERY ROOM	1,765,110	32,428	48,130	245,327	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,615,993	83,907	124,538	192,533	52.00
53.00 05300	ANESTHESIOLOGY	267,497	8,848	13,133	5,620	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,127,437	256,407	380,568	733,037	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	7,368,401	105,925	157,218	480,767	60.00
65.00 06500	RESPIRATORY THERAPY	1,038,968	35,521	52,722	119,297	65.00
66.00 06600	PHYSICAL THERAPY	2,660,870	105,503	156,591	358,067	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	2,342,943	54,357	80,679	247,555	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,210,412	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,274,434	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,605,172	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	558,877	0	0	0	74.00
76.00 03020	CARDIAC REHAB	0	0	0	0	76.00
76.02 03951	GUI DANCE	228,621	0	0	29,508	76.02
76.03 03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00 09100	EMERGENCY	6,418,324	212,636	315,602	685,035	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	180,148	0	0	45,112	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	129,349,748	4,553,006	6,757,732	7,836,826	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	69,267	0	0	9,725	192.00
192.01 19201	CHIROPRACTIC WORKS LESSEE	0	0	0	0	192.01
194.00 07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01 07951	SENIOR CIRCLE	113,565	1,994	2,959	7,206	194.01
194.02 07952	MARKETING	1,566,574	0	0	56,281	194.02
194.03 07953	VISTA MEDICAL CENTER WEST	139,432	0	0	21,090	194.03
194.04 07954	ABBOTT RESEARCH	0	227,328	0	0	194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	131,238,586	4,782,328	6,760,691	7,931,128	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet B Part I Date/Time Prepared: 5/11/2015 7:37 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,280,631			5.00
7.00	00700	OPERATION OF PLANT	1,760,491	9,924,330		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	275,642	291,647	1,845,508	8.00
9.00	00900	HOUSEKEEPING	368,652	159,494	0	2,237,676
10.00	01000	DIETARY	707,610	516,279	0	133,264
11.00	01100	CAFETERIA	1,768	0	0	0
13.00	01300	NURSING ADMINISTRATION	819,591	87,546	0	22,598
14.00	01400	CENTRAL SERVICES & SUPPLY	331,516	397,015	50,799	102,479
15.00	01500	PHARMACY	492,757	116,763	0	30,139
16.00	01600	MEDICAL RECORDS & LIBRARY	633,387	185,480	0	47,877
17.00	01700	SOCIAL SERVICE	3,562	15,216	0	3,928
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,446,071	2,673,320	751,939	690,046
31.00	03100	INTENSIVE CARE UNIT	1,150,870	478,134	155,957	123,418
40.00	04000	SUBPROVIDER - I PF	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0
43.00	04300	NURSERY	332,567	87,372	19,348	22,553
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,474,087	936,883	168,508	241,831
51.00	05100	RECOVERY ROOM	450,913	114,713	73,648	29,610
52.00	05200	DELIVERY ROOM & LABOR ROOM	434,950	296,823	165,198	76,617
53.00	05300	ANESTHESIOLOGY	63,636	31,301	0	8,080
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,048,077	907,041	137,838	234,128
54.01	05401	ULTRASOUND	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MRI	0	0	0	0
60.00	06000	LABORATORY	1,749,379	374,711	0	96,722
65.00	06500	RESPIRATORY THERAPY	268,803	125,657	4,790	32,435
66.00	06600	PHYSICAL THERAPY	707,538	373,218	413	96,336
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	587,748	192,289	33,843	49,634
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	476,664	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,137,405	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,208,727	0	0	0
74.00	07400	RENAL DIALYSIS	120,519	0	0	0
76.00	03020	CARDIAC REHAB	0	0	0	0
76.02	03951	GUI DANCE	55,664	0	0	0
76.03	03952	WOUND CARE	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
91.00	09100	EMERGENCY	1,645,716	752,202	283,227	194,161
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				31,821
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	48,576	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,802,886	9,113,104	1,845,508	2,235,856
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,034	0	0	385,916
192.01	19201	CHIROPRACTIC WORKS LESSEE	0	0	0	0
194.00	07950	CLINIC CORPORATION	0	0	0	0
194.01	07951	SENIOR CIRCLE	27,112	7,052	0	1,820
194.02	07952	MARKETING	349,961	0	0	0
194.03	07953	VISTA MEDICAL CENTER WEST	34,616	0	0	0
194.04	07954	ABBOTT RESEARCH	49,022	804,174	0	0
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	23,280,631	9,924,330	1,845,508	2,237,676

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet B Part I Date/Time Prepared: 5/11/2015 7:37 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	9,965					11.00
13.00	01300		4,730,819				13.00
14.00	01400	192	0	2,419,325			14.00
15.00	01500	319	0	12,964	2,937,979		15.00
16.00	01600	285	0	2,755	0	3,806,958	16.00
17.00	01700	2	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,597	1,974,531	128,500	0	347,281	30.00
31.00	03100	685	666,825	65,466	0	86,913	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	206	191,637	13,259	0	18,027	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	656	526,501	318,381	0	717,109	50.00
51.00	05100	299	298,111	4,125	0	73,316	51.00
52.00	05200	251	233,958	39,944	0	22,007	52.00
53.00	05300	16	6,829	39,688	0	19,855	53.00
54.00	05400	999	0	77,156	0	717,350	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	877	0	217,948	0	421,697	60.00
65.00	06500	189	0	30,831	0	56,932	65.00
66.00	06600	471	0	3,861	0	64,184	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	307	0	43,424	0	204,398	69.00
71.00	07100	0	0	350,960	0	46,851	71.00
72.00	07200	0	0	924,292	0	115,156	72.00
73.00	07300	0	0	0	2,937,979	483,902	73.00
74.00	07400	0	0	0	0	13,012	74.00
76.00	03020	0	0	0	0	0	76.00
76.02	03951	54	0	117	0	983	76.02
76.03	03952	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	944	832,427	130,635	0	397,985	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	79	0	10,794	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		9,862	4,730,819	2,415,100	2,937,979	3,806,958	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	10	0	135	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	59	0	3,943	0	0	194.01
194.02	07952	17	0	147	0	0	194.02
194.03	07953	17	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		9,965	4,730,819	2,419,325	2,937,979	3,806,958	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet B
Part I
Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		SERVICES-SALARY & FRINGES APPRV				
	17.00	21.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	39,225				17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			21.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	31,571	0	29,893,203	0	30.00
31.00 03100	INTENSIVE CARE UNIT	4,878	0	8,423,578	0	31.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00 04300	NURSERY	2,776	0	2,229,940	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	11,219,667	0	50.00
51.00 05100	RECOVERY ROOM	0	0	3,135,730	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	3,286,719	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	464,503	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	13,620,038	0	54.00
54.01 05401	ULTRASOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	0	0	10,973,645	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	1,766,145	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	4,527,052	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	3,837,177	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,084,887	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,451,287	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	10,235,780	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	692,408	0	74.00
76.00 03020	CARDIAC REHAB	0	0	0	0	76.00
76.02 03951	GUI DANCE	0	0	314,947	0	76.02
76.03 03952	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00 09100	EMERGENCY	0	0	11,900,715	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	284,709	0	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	39,225	0	127,342,130	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	482,087	0	192.00
192.01 19201	CHIROPRACTIC WORKS LESSEE	0	0	0	0	192.01
194.00 07950	CLINIC CORPORATION	0	0	0	0	194.00
194.01 07951	SENIOR CIRCLE	0	0	165,710	0	194.01
194.02 07952	MARKETING	0	0	1,972,980	0	194.02
194.03 07953	VISTA MEDICAL CENTER WEST	0	0	195,155	0	194.03
194.04 07954	ABBOTT RESEARCH	0	0	1,080,524	0	194.04
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	39,225	0	131,238,586	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet B Part II Date/Time Prepared: 5/11/2015 7:37 am	
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	73,556	109,175	182,731
5.00	00500	ADMINISTRATIVE & GENERAL	0	555,788	824,920	1,380,708
7.00	00700	OPERATION OF PLANT	0	1,347,528	2,000,046	3,347,574
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,444	122,366	204,810
9.00	00900	HOUSEKEEPING	0	45,086	66,919	112,005
10.00	01000	DIETARY	0	145,944	216,616	362,560
11.00	01100	CAFETERIA	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	24,748	36,732	61,480
14.00	01400	CENTRAL SERVICES & SUPPLY	0	112,230	166,576	278,806
15.00	01500	PHARMACY	0	33,007	48,990	81,997
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,432	77,822	130,254
17.00	01700	SOCIAL SERVICE	0	4,301	6,384	10,685
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	755,707	1,121,646	1,877,353
31.00	03100	INTENSIVE CARE UNIT	0	135,161	200,611	335,772
40.00	04000	SUBPROVIDER - IPF	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0
43.00	04300	NURSERY	0	24,699	36,659	61,358
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	264,843	393,089	657,932
51.00	05100	RECOVERY ROOM	0	32,428	48,130	80,558
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	83,907	124,538	208,445
53.00	05300	ANESTHESIOLOGY	0	8,848	13,133	21,981
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	256,407	380,568	636,975
54.01	05401	ULTRASOUND	0	0	0	0
56.00	05600	RADIOLOGY-SOFT	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MRI	0	0	0	0
60.00	06000	LABORATORY	0	105,925	157,218	263,143
65.00	06500	RESPIRATORY THERAPY	0	35,521	52,722	88,243
66.00	06600	PHYSICAL THERAPY	0	105,503	156,591	262,094
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	54,357	80,679	135,036
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0
76.00	03020	CARDIAC REHAB	0	0	0	0
76.02	03951	WOUND CARE	0	0	0	680
76.03	03952	WOUND CARE	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
91.00	09100	EMERGENCY	0	212,636	315,602	528,238
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,039
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,553,006	6,757,732	11,310,738
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	224
192.01	19201	CHIROPRACTIC WORKS LESSEE	0	0	0	0
194.00	07950	CLINIC CORPORATION	0	0	0	0
194.01	07951	SENIOR CIRCLE	0	1,994	2,959	4,953
194.02	07952	MARKETING	0	0	0	1,297
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	486
194.04	07954	ABBOTT RESEARCH	0	227,328	0	227,328
200.00		Cross Foot Adjustments				0
201.00		Negative Cost Centers		0	0	0
202.00		TOTAL (sum lines 118-201)	0	4,782,328	6,760,691	11,543,019

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet B Part II Date/Time Prepared: 5/11/2015 7:37 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,401,818				5.00
7.00	00700	OPERATION OF PLANT	106,007	3,456,575			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,598	101,579	322,987		8.00
9.00	00900	HOUSEKEEPING	22,198	55,551	0	189,754	9.00
10.00	01000	DIETARY	42,608	179,816	0	11,301	596,285
11.00	01100	CAFETERIA	106	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	49,351	30,492	0	1,916	0
14.00	01400	CENTRAL SERVICES & SUPPLY	19,962	138,278	8,891	8,690	0
15.00	01500	PHARMACY	29,671	40,668	0	2,556	0
16.00	01600	MEDICAL RECORDS & LIBRARY	38,139	64,601	0	4,060	0
17.00	01700	SOCIAL SERVICE	214	5,300	0	333	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	207,489	931,098	131,600	58,517	497,133
31.00	03100	INTENSIVE CARE UNIT	69,299	166,531	27,294	10,466	45,451
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
43.00	04300	NURSERY	20,025	30,431	3,386	1,912	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	88,762	326,310	29,491	20,507	0
51.00	05100	RECOVERY ROOM	27,152	39,954	12,889	2,511	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,190	103,381	28,912	6,497	0
53.00	05300	ANESTHESIOLOGY	3,832	10,902	0	685	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	123,324	315,916	24,123	19,854	0
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	105,338	130,509	0	8,202	0
65.00	06500	RESPIRATORY THERAPY	16,186	43,765	838	2,750	0
66.00	06600	PHYSICAL THERAPY	42,604	129,989	72	8,169	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	35,391	66,973	5,923	4,209	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,702	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,489	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	72,783	0	0	0	0
74.00	07400	RENAL DIALYSIS	7,257	0	0	0	0
76.00	03020	CARDIAC REHAB	0	0	0	0	0
76.02	03951	GUI DANCE	3,352	0	0	0	0
76.03	03952	WOUND CARE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	99,096	261,987	49,568	16,465	4,091
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,925	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,373,050	3,174,031	322,987	189,600	546,675
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,026	0	0	0	49,610
192.01	19201	CHIROPRACTIC WORKS LESSEE	0	0	0	0	0
194.00	07950	CLINIC CORPORATION	0	0	0	0	0
194.01	07951	SENIOR CIRCLE	1,633	2,456	0	154	0
194.02	07952	MARKETING	21,073	0	0	0	0
194.03	07953	VISTA MEDICAL CENTER WEST	2,084	0	0	0	0
194.04	07954	ABBOTT RESEARCH	2,952	280,088	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,401,818	3,456,575	322,987	189,754	596,285

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet B Part II Date/Time Prepared: 5/11/2015 7:37 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	106					11.00
13.00	01300	5	153,354				13.00
14.00	01400	2	0	455,993			14.00
15.00	01500	3	0	2,444	163,012		15.00
16.00	01600	3	0	519	0	240,786	16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	28	64,006	24,220	0	21,986	30.00
31.00	03100	7	21,616	12,339	0	5,502	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	2	6,212	2,499	0	1,141	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7	17,067	60,008	0	45,400	50.00
51.00	05100	3	9,664	777	0	4,642	51.00
52.00	05200	3	7,584	7,529	0	1,393	52.00
53.00	05300	0	221	7,480	0	1,257	53.00
54.00	05400	11	0	14,542	0	45,187	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	9	0	41,079	0	26,697	60.00
65.00	06500	2	0	5,811	0	3,604	65.00
66.00	06600	5	0	728	0	4,063	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	3	0	8,185	0	12,940	69.00
71.00	07100	0	0	66,149	0	2,966	71.00
72.00	07200	0	0	174,209	0	7,290	72.00
73.00	07300	0	0	0	163,012	30,636	73.00
74.00	07400	0	0	0	0	824	74.00
76.00	03020	0	0	0	0	0	76.00
76.02	03951	1	0	22	0	62	76.02
76.03	03952	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	10	26,984	24,622	0	25,196	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	1	0	2,034	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		105	153,354	455,196	163,012	240,786	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	26	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	1	0	743	0	0	194.01
194.02	07952	0	0	28	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		106	153,354	455,993	163,012	240,786	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet B Part II Date/Time Prepared: 5/11/2015 7:37 am	
Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	21.00				
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	16,546			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,318	3,864,180	0	3,864,180 30.00
31.00	03100	INTENSIVE CARE UNIT	2,057	708,978	0	708,978 31.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0 41.00
43.00	04300	NURSERY	1,171	131,771	0	131,771 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,255,467	0	1,255,467 50.00
51.00	05100	RECOVERY ROOM	0	183,802	0	183,802 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	394,370	0	394,370 52.00
53.00	05300	ANESTHESIOLOGY	0	46,487	0	46,487 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,196,822	0	1,196,822 54.00
54.01	05401	ULTRASOUND	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0 58.00
60.00	06000	LABORATORY	0	586,054	0	586,054 60.00
65.00	06500	RESPIRATORY THERAPY	0	163,948	0	163,948 65.00
66.00	06600	PHYSICAL THERAPY	0	455,974	0	455,974 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	274,364	0	274,364 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	97,817	0	97,817 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	249,988	0	249,988 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	266,431	0	266,431 73.00
74.00	07400	RENAL DIALYSIS	0	8,081	0	8,081 74.00
76.00	03020	CARDIAC REHAB	0	0	0	0 76.00
76.02	03951	GUI DANCE	0	4,117	0	4,117 76.02
76.03	03952	WOUND CARE	0	0	0	0 76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0 88.00
91.00	09100	EMERGENCY	0	1,052,041	0	1,052,041 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,999	0	5,999 95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,546	10,946,691	0	10,946,691 118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,886	0	50,886 192.00
192.01	19201	CHIROPRACTIC WORKS LESSEE	0	0	0	0 192.01
194.00	07950	CLINIC CORPORATION	0	0	0	0 194.00
194.01	07951	SENIOR CIRCLE	0	10,106	0	10,106 194.01
194.02	07952	MARKETING	0	22,398	0	22,398 194.02
194.03	07953	VISTA MEDICAL CENTER WEST	0	2,570	0	2,570 194.03
194.04	07954	ABBOTT RESEARCH	0	510,368	0	510,368 194.04
200.00		Cross Foot Adjustments	0	0	0	0 200.00
201.00		Negative Cost Centers	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	16,546	11,543,019	0	11,543,019 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1

Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	486,968				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		463,820			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	7,490	7,490	52,435,370		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	56,594	56,594	6,057,286	-23,280,631	107,957,955
7.00 00700	OPERATION OF PLANT	137,214	137,214	859,161	0	8,163,839
8.00 00800	LAUNDRY & LINEN SERVICE	8,395	8,395	0	0	1,278,219
9.00 00900	HOUSEKEEPING	4,591	4,591	0	0	1,709,530
10.00 01000	DIETARY	14,861	14,861	0	0	3,281,363
11.00 01100	CAFETERIA	0	0	0	0	8,197
13.00 01300	NURSING ADMINISTRATION	2,520	2,520	2,901,083	0	3,800,650
14.00 01400	CENTRAL SERVICES & SUPPLY	11,428	11,428	391,467	0	1,537,324
15.00 01500	PHARMACY	3,361	3,361	1,627,829	0	2,285,037
16.00 01600	MEDICAL RECORDS & LIBRARY	5,339	5,339	921,029	0	2,937,174
17.00 01700	SOCIAL SERVICE	438	438	4,044	0	16,517
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	76,951	76,951	10,742,889	0	15,980,129
31.00 03100	INTENSIVE CARE UNIT	13,763	13,763	3,628,010	0	5,336,871
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0
43.00 04300	NURSERY	2,515	2,515	1,042,646	0	1,542,195
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	26,968	26,968	2,864,547	0	6,835,711
51.00 05100	RECOVERY ROOM	3,302	3,302	1,621,942	0	2,090,995
52.00 05200	DELIVERY ROOM & LABOR ROOM	8,544	8,544	1,272,901	0	2,016,971
53.00 05300	ANESTHESIOLOGY	901	901	37,153	0	295,098
54.00 05400	RADIOLOGY-DIAGNOSTIC	26,109	26,109	4,846,364	0	9,497,449
54.01 05401	ULTRASOUND	0	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	0	0	0	0	0
60.00 06000	LABORATORY	10,786	10,786	3,178,519	0	8,112,311
65.00 06500	RESPIRATORY THERAPY	3,617	3,617	788,712	0	1,246,508
66.00 06600	PHYSICAL THERAPY	10,743	10,743	2,367,305	0	3,281,031
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	5,535	5,535	1,636,676	0	2,725,534
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,210,412
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,274,434
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,605,172
74.00 07400	RENAL DIALYSIS	0	0	0	0	558,877
76.00 03020	CARDIAC REHAB	0	0	0	0	0
76.02 03951	GUI DANCE	0	0	195,086	0	258,129
76.03 03952	WOUND CARE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	21,652	21,652	4,529,005	0	7,631,597
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	298,252	0	225,260
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	0
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	463,617	463,617	51,811,906	-23,280,631	105,742,534
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	64,297	0	78,992
192.01 19201	CHIROPRACTIC WORKS LESSEE	0	0	0	0	0
194.00 07950	CLINIC CORPORATION	0	0	0	0	0
194.01 07951	SENIOR CIRCLE	203	203	47,640	0	125,724
194.02 07952	MARKETING	0	0	372,095	0	1,622,855
194.03 07953	VISTA MEDICAL CENTER WEST	0	0	139,432	0	160,522
194.04 07954	ABBOTT RESEARCH	23,148	0	0	0	227,328
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	4,782,328	6,760,691	7,931,128		23,280,631
203.00	Unit cost multiplier (Wkst. B, Part I)	9.820621	14.576109	0.151255		0.215645

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1

Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
204.00	Cost to be allocated (per Wkst. B, Part II)			182,731		1,401,818	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003485		0.012985	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet B-1	
Date/Time Prepared: 5/11/2015 7:37 am							
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	285,670				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,395	1,309,457			8.00
9.00	00900	HOUSEKEEPING	4,591	0	249,536		9.00
10.00	01000	DIETARY	14,861	0	14,861	130,171	10.00
11.00	01100	CAFETERIA	0	0	0	68,324	11.00
13.00	01300	NURSING ADMINISTRATION	2,520	0	2,520	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,428	36,044	11,428	0	14.00
15.00	01500	PHARMACY	3,361	0	3,361	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,339	0	5,339	0	16.00
17.00	01700	SOCIAL SERVICE	438	0	438	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	76,951	533,529	76,951	108,526	17,799
31.00	03100	INTENSIVE CARE UNIT	13,763	110,657	13,763	9,922	4,694
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
43.00	04300	NURSERY	2,515	13,728	2,515	0	1,412
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	26,968	119,563	26,968	0	4,497
51.00	05100	RECOVERY ROOM	3,302	52,256	3,302	0	2,052
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,544	117,214	8,544	0	1,724
53.00	05300	ANESTHESIOLOGY	901	0	901	0	107
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,109	97,801	26,109	0	6,849
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	10,786	0	10,786	0	6,013
65.00	06500	RESPIRATORY THERAPY	3,617	3,399	3,617	0	1,293
66.00	06600	PHYSICAL THERAPY	10,743	293	10,743	0	3,231
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	5,535	24,013	5,535	0	2,106
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03020	CARDIAC REHAB	0	0	0	0	0
76.02	03951	GUIDANCE	0	0	0	0	367
76.03	03952	WOUND CARE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	21,652	200,960	21,652	893	6,474
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	545
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	262,319	1,309,457	249,333	119,341	67,610
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	10,830	71
192.01	19201	CHIROPRACTIC WORKS LESSEE	0	0	0	0	0
194.00	07950	CLINIC CORPORATION	0	0	0	0	0
194.01	07951	SENIOR CIRCLE	203	0	203	0	406
194.02	07952	MARKETING	0	0	0	0	119
194.03	07953	VISTA MEDICAL CENTER WEST	0	0	0	0	118
194.04	07954	ABBOTT RESEARCH	23,148	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)	9,924,330	1,845,508	2,237,676	4,638,516	9,965
203.00		Unit cost multiplier (Wkst. B, Part I)	34.740540	1.409369	8.967347	35.634020	0.145849
204.00		Cost to be allocated (per Wkst. B, Part II)	3,456,575	322,987	189,754	596,285	106

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1

Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	12.099888	0.246657	0.760427	4.580782	0.001551	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1

Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS G HR)	CENTRAL SERVICES & SUPPLY (TOTAL SUPP LIE)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (PT. DAYS & OP OB)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
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	25,739,093					13.00
14.00	01400	0	13,805,838				14.00
15.00	01500	0	73,981	5,610,699			15.00
16.00	01600	0	15,723	0	1,095,659,668		16.00
17.00	01700	0	0	0	0	47,850	17.00
21.00	02100	0	0	0	0	0	21.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,742,888	733,285	0	99,937,053	38,514	30.00
31.00	03100	3,628,010	373,579	0	25,010,931	5,950	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	1,042,647	75,661	0	5,187,491	3,386	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,864,547	1,816,839	0	206,362,310	0	50.00
51.00	05100	1,621,942	23,539	0	21,098,140	0	51.00
52.00	05200	1,272,901	227,938	0	6,333,076	0	52.00
53.00	05300	37,153	226,482	0	5,713,529	0	53.00
54.00	05400	0	440,292	0	206,564,478	0	54.00
54.01	05401	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	1,243,718	0	121,351,561	0	60.00
65.00	06500	0	175,938	0	16,383,220	0	65.00
66.00	06600	0	22,033	0	18,470,117	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	247,799	0	58,819,447	0	69.00
71.00	07100	0	2,002,751	0	13,482,269	0	71.00
72.00	07200	0	5,274,434	0	33,138,550	0	72.00
73.00	07300	0	0	5,610,699	139,252,378	0	73.00
74.00	07400	0	0	0	3,744,324	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.02	03951	0	670	0	282,841	0	76.02
76.03	03952	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	4,529,005	745,466	0	114,527,953	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	61,595	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		25,739,093	13,781,723	5,610,699	1,095,659,668	47,850	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	773	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	22,502	0	0	0	194.01
194.02	07952	0	840	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		4,730,819	2,419,325	2,937,979	3,806,958	39,225	202.00
203.00		0.183799	0.175239	0.523639	0.003475	0.819749	203.00
204.00		153,354	455,993	163,012	240,786	16,546	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1

Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS G HR)	CENTRAL SERVICES & SUPPLY (TOTAL SUPP LIE)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (PT. DAYS & OP OB)	
		13.00	14.00	15.00	16.00	17.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.005958	0.033029	0.029054	0.000220	0.345789	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1
Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		INTERNS & RESIDENTS	
		SERVICES-SALARY & FRINGES	
		APPRV (ASSIGNED TIME)	
		21.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - I PF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	CARDIAC REHAB	76.00
76.02	03951	GUIDANCE	76.02
76.03	03952	WOUND CARE	76.03
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	CHIROPRACTIC WORKS LESSEE	192.01
194.00	07950	CLINIC CORPORATION	194.00
194.01	07951	SENIOR CIRCLE	194.01
194.02	07952	MARKETING	194.02
194.03	07953	VISTA MEDICAL CENTER WEST	194.03
194.04	07954	ABBOTT RESEARCH	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet B-1
Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		INTERNS & RESIDENTS		
		SERVICES-SALARY & FRINGES APPROV (ASSIGNED TIME) 21.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet C Part I Date/Time Prepared: 5/11/2015 7:37 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		29,893,203	0	29,893,203
31.00	03100 INTENSIVE CARE UNIT		8,423,578	0	8,423,578
40.00	04000 SUBPROVIDER - I PF		0	0	0
41.00	04100 SUBPROVIDER - I RF		0	0	0
43.00	04300 NURSERY		2,229,940	0	2,229,940
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		11,219,667	0	11,219,667
51.00	05100 RECOVERY ROOM		3,135,730	0	3,135,730
52.00	05200 DELIVERY ROOM & LABOR ROOM		3,286,719	0	3,286,719
53.00	05300 ANESTHESIOLOGY		464,503	0	464,503
54.00	05400 RADIOLOGY-DIAGNOSTIC		13,620,038	0	13,620,038
54.01	05401 ULTRASOUND		0	0	0
56.00	05600 RADIO SOTOPE		0	0	0
57.00	05700 CT SCAN		0	0	0
58.00	05800 MRI		0	0	0
60.00	06000 LABORATORY		10,973,645	0	10,973,645
65.00	06500 RESPIRATORY THERAPY	0	1,766,145	0	1,766,145
66.00	06600 PHYSICAL THERAPY	0	4,527,052	0	4,527,052
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY		3,837,177	0	3,837,177
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		3,084,887	0	3,084,887
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,451,287	0	7,451,287
73.00	07300 DRUGS CHARGED TO PATIENTS		10,235,780	0	10,235,780
74.00	07400 RENAL DIALYSIS		692,408	0	692,408
76.00	03020 CARDIAC REHAB		0	0	0
76.02	03951 GUIDANCE		314,947	0	314,947
76.03	03952 WOUND CARE		0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC		0	0	0
91.00	09100 EMERGENCY		11,900,715	0	11,900,715
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,336,655	0	1,336,655
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		284,709	0	284,709
101.00	10100 HOME HEALTH AGENCY		0	0	0
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE		0	0	0
200.00	Subtotal (see instructions)		128,678,785	0	128,678,785
201.00	Less Observation Beds		1,336,655	0	1,336,655
202.00	Total (see instructions)		127,342,130	0	127,342,130

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet C Part I Date/Time Prepared: 5/11/2015 7:37 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	95,297,367		95,297,367			30.00
31.00	03100	INTENSIVE CARE UNIT	25,010,931		25,010,931			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	5,187,491		5,187,491			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	121,690,068	84,672,242	206,362,310	0.054369	0.000000	50.00
51.00	05100	RECOVERY ROOM	8,491,521	12,606,619	21,098,140	0.148626	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,591,483	741,593	6,333,076	0.518977	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,700,460	2,013,069	5,713,529	0.081299	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,636,163	147,928,315	206,564,478	0.065936	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIO SOTOP	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	67,202,901	54,148,660	121,351,561	0.090429	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	14,772,281	1,610,939	16,383,220	0.107802	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,133,708	11,336,409	18,470,117	0.245101	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	39,794,987	19,024,460	58,819,447	0.065237	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,664,072	3,818,197	13,482,269	0.228811	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,192,755	8,945,795	33,138,550	0.224853	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,067,223	34,185,155	139,252,378	0.073505	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,714,914	29,410	3,744,324	0.184922	0.000000	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00
76.02	03951	GUI DANCE	48,657	234,184	282,841	1.113513	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
91.00	09100	EMERGENCY	31,010,967	83,516,986	114,527,953	0.103911	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,183,407	3,456,279	4,639,686	0.288092	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	627,391,356	468,268,312	1,095,659,668			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	627,391,356	468,268,312	1,095,659,668			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet C Part I Date/Time Prepared: 5/11/2015 7:37 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
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.054369		50.00
51.00	05100 RECOVERY ROOM	0.148626		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.518977		52.00
53.00	05300 ANESTHESIOLOGY	0.081299		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.065936		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.090429		60.00
65.00	06500 RESPIRATORY THERAPY	0.107802		65.00
66.00	06600 PHYSICAL THERAPY	0.245101		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.065237		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228811		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.224853		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.073505		73.00
74.00	07400 RENAL DIALYSIS	0.184922		74.00
76.00	03020 CARDIAC REHAB	0.000000		76.00
76.02	03951 GUIDANCE	1.113513		76.02
76.03	03952 WOUND CARE	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
91.00	09100 EMERGENCY	0.103911		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.288092		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet C Part I Date/Time Prepared: 5/11/2015 7:37 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		29,893,203	0	29,893,203
31.00	03100 INTENSIVE CARE UNIT		8,423,578	0	8,423,578
40.00	04000 SUBPROVIDER - I PF		0	0	0
41.00	04100 SUBPROVIDER - I RF		0	0	0
43.00	04300 NURSERY		2,229,940	0	2,229,940
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		11,219,667	0	11,219,667
51.00	05100 RECOVERY ROOM		3,135,730	0	3,135,730
52.00	05200 DELIVERY ROOM & LABOR ROOM		3,286,719	0	3,286,719
53.00	05300 ANESTHESIOLOGY		464,503	0	464,503
54.00	05400 RADIOLOGY-DIAGNOSTIC		13,620,038	0	13,620,038
54.01	05401 ULTRASOUND		0	0	0
56.00	05600 RADIOLOGY		0	0	0
57.00	05700 CT SCAN		0	0	0
58.00	05800 MRI		0	0	0
60.00	06000 LABORATORY		10,973,645	0	10,973,645
65.00	06500 RESPIRATORY THERAPY	0	1,766,145	0	1,766,145
66.00	06600 PHYSICAL THERAPY	0	4,527,052	0	4,527,052
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY		3,837,177	0	3,837,177
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		3,084,887	0	3,084,887
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7,451,287	0	7,451,287
73.00	07300 DRUGS CHARGED TO PATIENTS		10,235,780	0	10,235,780
74.00	07400 RENAL DIALYSIS		692,408	0	692,408
76.00	03020 CARDIAC REHAB		0	0	0
76.02	03951 GUIDANCE		314,947	0	314,947
76.03	03952 WOUND CARE		0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC		0	0	0
91.00	09100 EMERGENCY		11,900,715	0	11,900,715
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,336,655	0	1,336,655
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES		284,709	0	284,709
101.00	10100 HOME HEALTH AGENCY		0	0	0
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE		0	0	0
200.00	Subtotal (see instructions)		128,678,785	0	128,678,785
201.00	Less Observation Beds		1,336,655	0	1,336,655
202.00	Total (see instructions)		127,342,130	0	127,342,130

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet C Part I Date/Time Prepared: 5/11/2015 7:37 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	95,297,367		95,297,367			30.00
31.00	03100	INTENSIVE CARE UNIT	25,010,931		25,010,931			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	5,187,491		5,187,491			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	121,690,068	84,672,242	206,362,310	0.054369	0.000000	50.00
51.00	05100	RECOVERY ROOM	8,491,521	12,606,619	21,098,140	0.148626	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,591,483	741,593	6,333,076	0.518977	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,700,460	2,013,069	5,713,529	0.081299	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,636,163	147,928,315	206,564,478	0.065936	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOLOGY	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	67,202,901	54,148,660	121,351,561	0.090429	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	14,772,281	1,610,939	16,383,220	0.107802	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,133,708	11,336,409	18,470,117	0.245101	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	39,794,987	19,024,460	58,819,447	0.065237	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,664,072	3,818,197	13,482,269	0.228811	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,192,755	8,945,795	33,138,550	0.224853	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,067,223	34,185,155	139,252,378	0.073505	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,714,914	29,410	3,744,324	0.184922	0.000000	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00
76.02	03951	GUI DANCE	48,657	234,184	282,841	1.113513	0.000000	76.02
76.03	03952	WOUND CARE	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
91.00	09100	EMERGENCY	31,010,967	83,516,986	114,527,953	0.103911	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,183,407	3,456,279	4,639,686	0.288092	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	627,391,356	468,268,312	1,095,659,668			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	627,391,356	468,268,312	1,095,659,668			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet C Part I Date/Time Prepared: 5/11/2015 7:37 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.054369		50.00
51.00	05100 RECOVERY ROOM	0.148626		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.518977		52.00
53.00	05300 ANESTHESIOLOGY	0.081299		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.065936		54.00
54.01	05401 ULTRASOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.090429		60.00
65.00	06500 RESPIRATORY THERAPY	0.107802		65.00
66.00	06600 PHYSICAL THERAPY	0.245101		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.065237		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228811		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.224853		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.073505		73.00
74.00	07400 RENAL DIALYSIS	0.184922		74.00
76.00	03020 CARDIAC REHAB	0.000000		76.00
76.02	03951 GUIDANCE	1.113513		76.02
76.03	03952 WOUND CARE	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100 EMERGENCY	0.103911		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.288092		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet C
Part II
Date/Time Prepared:
5/11/2015 7:37 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	11,219,667	1,255,467	9,964,200	0	0	50.00
51.00	05100	RECOVERY ROOM	3,135,730	183,802	2,951,928	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,286,719	394,370	2,892,349	0	0	52.00
53.00	05300	ANESTHESIOLOGY	464,503	46,487	418,016	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,620,038	1,196,822	12,423,216	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	10,973,645	586,054	10,387,591	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,766,145	163,948	1,602,197	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,527,052	455,974	4,071,078	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	3,837,177	274,364	3,562,813	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,084,887	97,817	2,987,070	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,451,287	249,988	7,201,299	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,235,780	266,431	9,969,349	0	0	73.00
74.00	07400	RENAL DIALYSIS	692,408	8,081	684,327	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.02	03951	GUIDANCE	314,947	4,117	310,830	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	11,900,715	1,052,041	10,848,674	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,336,655	172,784	1,163,871	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	284,709	5,999	278,710	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	88,132,064	6,414,546	81,717,518	0	0	200.00
201.00		Less Observation Beds	1,336,655	172,784	1,163,871	0	0	201.00
202.00		Total (line 200 minus line 201)	86,795,409	6,241,762	80,553,647	0	0	202.00

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

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet C
Part II
Date/Time Prepared:
5/11/2015 7:37 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)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	11,219,667	206,362,310	0.054369	50.00
51.00	05100 RECOVERY ROOM	3,135,730	21,098,140	0.148626	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,286,719	6,333,076	0.518977	52.00
53.00	05300 ANESTHESIOLOGY	464,503	5,713,529	0.081299	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	13,620,038	206,564,478	0.065936	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700 CT SCAN	0	0	0.000000	57.00
58.00	05800 MRI	0	0	0.000000	58.00
60.00	06000 LABORATORY	10,973,645	121,351,561	0.090429	60.00
65.00	06500 RESPIRATORY THERAPY	1,766,145	16,383,220	0.107802	65.00
66.00	06600 PHYSICAL THERAPY	4,527,052	18,470,117	0.245101	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	3,837,177	58,819,447	0.065237	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,084,887	13,482,269	0.228811	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,451,287	33,138,550	0.224853	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,235,780	139,252,378	0.073505	73.00
74.00	07400 RENAL DIALYSIS	692,408	3,744,324	0.184922	74.00
76.00	03020 CARDIAC REHAB	0	0	0.000000	76.00
76.02	03951 GUIDANCE	314,947	282,841	1.113513	76.02
76.03	03952 WOUND CARE	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	88.00
91.00	09100 EMERGENCY	11,900,715	114,527,953	0.103911	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,336,655	4,639,686	0.288092	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	284,709	0	0.000000	95.00
101.00	10100 HOME HEALTH AGENCY	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE	0	0	0.000000	116.00
200.00	Subtotal (sum of lines 50 thru 199)	88,132,064	970,163,879		200.00
201.00	Less Observation Beds	1,336,655	0		201.00
202.00	Total (line 200 minus line 201)	86,795,409	970,163,879		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part I Date/Time Prepared: 5/11/2015 7:37 am
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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	3,864,180	0	3,864,180	39,987	96.64	30.00
31.00	INTENSIVE CARE UNIT	708,978		708,978	5,950	119.16	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
43.00	NURSERY	131,771		131,771	3,386	38.92	43.00
200.00	Total (lines 30-199)	4,704,929		4,704,929	49,323		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	17,235	1,665,590	30.00
31.00	INTENSIVE CARE UNIT	3,157	376,188	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	20,392	2,041,778	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part II Date/Time Prepared: 5/11/2015 7:37 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,255,467	206,362,310	0.006084	45,019,566	273,899	50.00
51.00	05100 RECOVERY ROOM	183,802	21,098,140	0.008712	2,360,548	20,565	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	394,370	6,333,076	0.062271	25,002	1,557	52.00
53.00	05300 ANESTHESIOLOGY	46,487	5,713,529	0.008136	926,225	7,536	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,196,822	206,564,478	0.005794	29,993,104	173,780	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	586,054	121,351,561	0.004829	31,718,362	153,168	60.00
65.00	06500 RESPIRATORY THERAPY	163,948	16,383,220	0.010007	8,035,082	80,407	65.00
66.00	06600 PHYSICAL THERAPY	455,974	18,470,117	0.024687	3,916,753	96,693	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	274,364	58,819,447	0.004665	18,525,664	86,422	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	97,817	13,482,269	0.007255	2,863,998	20,778	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	249,988	33,138,550	0.007544	11,586,645	87,410	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	266,431	139,252,378	0.001913	48,431,852	92,650	73.00
74.00	07400 RENAL DIALYSIS	8,081	3,744,324	0.002158	2,330,710	5,030	74.00
76.00	03020 CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.02	03951 GUIDANCE	4,117	282,841	0.014556	6,998	102	76.02
76.03	03952 WOUND CARE	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100 EMERGENCY	1,052,041	114,527,953	0.009186	13,642,116	125,316	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	172,784	4,639,686	0.037240	628,981	23,423	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	6,408,547	970,163,879		220,011,606	1,248,736	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet D Part III Date/Time Prepared: 5/11/2015 7:37 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	39,987	0.00	17,235	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,950	0.00	3,157	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	0	41.00
43.00	04300	NURSERY	3,386	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	49,323		20,392	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet D
Part IV
Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	0	76.00
76.02	03951	GUIDANCE	0	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part IV Date/Time Prepared: 5/11/2015 7:37 am
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Cost Center Description		Title XVIII			Hospital		PPS	
		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	206,362,310	0.000000	0.000000	45,019,566	50.00
51.00	05100	RECOVERY ROOM	0	21,098,140	0.000000	0.000000	2,360,548	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,333,076	0.000000	0.000000	25,002	52.00
53.00	05300	ANESTHESIOLOGY	0	5,713,529	0.000000	0.000000	926,225	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	206,564,478	0.000000	0.000000	29,993,104	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	121,351,561	0.000000	0.000000	31,718,362	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,383,220	0.000000	0.000000	8,035,082	65.00
66.00	06600	PHYSICAL THERAPY	0	18,470,117	0.000000	0.000000	3,916,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	58,819,447	0.000000	0.000000	18,525,664	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,482,269	0.000000	0.000000	2,863,998	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,138,550	0.000000	0.000000	11,586,645	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	139,252,378	0.000000	0.000000	48,431,852	73.00
74.00	07400	RENAL DIALYSIS	0	3,744,324	0.000000	0.000000	2,330,710	74.00
76.00	03020	CARDIAC REHAB	0	0	0.000000	0.000000	0	76.00
76.02	03951	GUIDANCE	0	282,841	0.000000	0.000000	6,998	76.02
76.03	03952	WOUND CARE	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	114,527,953	0.000000	0.000000	13,642,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,639,686	0.000000	0.000000	628,981	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	970,163,879			220,011,606	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part IV Date/Time Prepared: 5/11/2015 7:37 am
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	26,254,119	0	50.00
51.00	05100 RECOVERY ROOM	0	3,024,842	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	45,403	0	52.00
53.00	05300 ANESTHESIOLOGY	0	437,859	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	35,394,035	0	54.00
54.01	05401 ULTRASOUND	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
60.00	06000 LABORATORY	0	6,101,947	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	475,788	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	7,970,404	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,008,578	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,511,133	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13,653,669	0	73.00
74.00	07400 RENAL DIALYSIS	0	23,627	0	74.00
76.00	03020 CARDIAC REHAB	0	0	0	76.00
76.02	03951 GUIDANCE	0	2,687	0	76.02
76.03	03952 WOUND CARE	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100 EMERGENCY	0	11,320,116	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	729,318	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	110,953,525	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part V Date/Time Prepared: 5/11/2015 7:37 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	0.054369	26,254,119	0	0	1,427,410	50.00
51.00	05100 RECOVERY ROOM	0.148626	3,024,842	0	0	449,570	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.518977	45,403	0	0	23,563	52.00
53.00	05300 ANESTHESIOLOGY	0.081299	437,859	0	0	35,597	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.065936	35,394,035	0	0	2,333,741	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.090429	6,101,947	0	0	551,793	60.00
65.00	06500 RESPIRATORY THERAPY	0.107802	475,788	0	0	51,291	65.00
66.00	06600 PHYSICAL THERAPY	0.245101	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.065237	7,970,404	0	0	519,965	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228811	1,008,578	0	0	230,774	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.224853	4,511,133	0	0	1,014,342	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.073505	13,653,669	0	39,267	1,003,613	73.00
74.00	07400 RENAL DIALYSIS	0.184922	23,627	0	0	4,369	74.00
76.00	03020 CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.02	03951 GUIDANCE	1.113513	2,687	0	0	2,992	76.02
76.03	03952 WOUND CARE	0.000000	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100 EMERGENCY	0.103911	11,320,116	0	0	1,176,285	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.288092	729,318	0	0	210,111	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.000000		0			95.00
200.00	Subtotal (see instructions)		110,953,525	0	39,267	9,035,416	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		110,953,525	0	39,267	9,035,416	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part V Date/Time Prepared: 5/11/2015 7:37 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
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,886	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 CARDIAC REHAB	0	0	76.00
76.02	03951 GUIDANCE	0	0	76.02
76.03	03952 WOUND CARE	0	0	76.03
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	2,886	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	2,886	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part I Date/Time Prepared: 5/11/2015 7:37 am
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Cost Center Description		Title XIX			Hospital	PPS		
		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	3,864,180	0	3,864,180	39,987	96.64	30.00	
31.00	INTENSIVE CARE UNIT	708,978		708,978	5,950	119.16	31.00	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00	
43.00	NURSERY	131,771		131,771	3,386	38.92	43.00	
200.00	Total (lines 30-199)	4,704,929		4,704,929	49,323		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	6,326	611,345					30.00
31.00	INTENSIVE CARE UNIT	211	25,143					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	0	0					41.00
43.00	NURSERY	2,435	94,770					43.00
200.00	Total (lines 30-199)	8,972	731,258					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part II Date/Time Prepared: 5/11/2015 7:37 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,255,467	206,362,310	0.006084	0	0	50.00
51.00	05100 RECOVERY ROOM	183,802	21,098,140	0.008712	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	394,370	6,333,076	0.062271	0	0	52.00
53.00	05300 ANESTHESIOLOGY	46,487	5,713,529	0.008136	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,196,822	206,564,478	0.005794	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	586,054	121,351,561	0.004829	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	163,948	16,383,220	0.010007	0	0	65.00
66.00	06600 PHYSICAL THERAPY	455,974	18,470,117	0.024687	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	274,364	58,819,447	0.004665	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	97,817	13,482,269	0.007255	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	249,988	33,138,550	0.007544	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	266,431	139,252,378	0.001913	0	0	73.00
74.00	07400 RENAL DIALYSIS	8,081	3,744,324	0.002158	0	0	74.00
76.00	03020 CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.02	03951 GUIDANCE	4,117	282,841	0.014556	0	0	76.02
76.03	03952 WOUND CARE	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100 EMERGENCY	1,052,041	114,527,953	0.009186	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	172,784	4,639,686	0.037240	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	6,408,547	970,163,879		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet D Part III Date/Time Prepared: 5/11/2015 7:37 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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	39,987	0.00	6,326	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,950	0.00	211	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
43.00	04300	NURSERY	3,386	0.00	2,435	0		43.00
200.00		Total (lines 30-199)	49,323		8,972	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet D
Part IV
Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
76.02	03951	GUIDANCE	0	0	0	0	0	76.02
76.03	03952	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part IV Date/Time Prepared: 5/11/2015 7:37 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	PPS	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)				
		6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	206,362,310	0.000000	0.000000		0	50.00
51.00	05100	RECOVERY ROOM	0	21,098,140	0.000000	0.000000		0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,333,076	0.000000	0.000000		0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,713,529	0.000000	0.000000		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	206,564,478	0.000000	0.000000		0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000		0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000		0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000		0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000		0	58.00
60.00	06000	LABORATORY	0	121,351,561	0.000000	0.000000		0	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,383,220	0.000000	0.000000		0	65.00
66.00	06600	PHYSICAL THERAPY	0	18,470,117	0.000000	0.000000		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000		0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000		0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	58,819,447	0.000000	0.000000		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,482,269	0.000000	0.000000		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,138,550	0.000000	0.000000		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	139,252,378	0.000000	0.000000		0	73.00
74.00	07400	RENAL DIALYSIS	0	3,744,324	0.000000	0.000000		0	74.00
76.00	03020	CARDIAC REHAB	0	0	0.000000	0.000000		0	76.00
76.02	03951	GUIDANCE	0	282,841	0.000000	0.000000		0	76.02
76.03	03952	WOUND CARE	0	0	0.000000	0.000000		0	76.03
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000		0	88.00
91.00	09100	EMERGENCY	0	114,527,953	0.000000	0.000000		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,639,686	0.000000	0.000000		0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	970,163,879				0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D Part IV Date/Time Prepared: 5/11/2015 7:37 am
		Title XIX	Hospital
			PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	60.00
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03020 CARDIAC REHAB	0	0	0	76.00
76.02	03951 GUIDANCE	0	0	0	76.02
76.03	03952 WOUND CARE	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D-1 Date/Time Prepared: 5/11/2015 7:37 am
Cost Center Description		Title XVIII	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)		39,987	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		39,987	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)		38,199	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)		17,235	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)		29,893,203	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)		29,893,203	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)		29,893,203	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)		747.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,884,369	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)		12,884,369	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,423,578	5,950	1,415.73	3,157	4,469,460	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)					19,625,577	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					36,979,406	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)					2,041,778	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,248,736	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,290,514	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					33,688,892	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,788	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					747.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,336,655	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet D-1 Date/Time Prepared: 5/11/2015 7:37 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	3,864,180	29,893,203	0.129266	1,336,655	172,784	90.00
91.00	Nursing School cost	0	29,893,203	0.000000	1,336,655	0	91.00
92.00	Allied health cost	0	29,893,203	0.000000	1,336,655	0	92.00
93.00	All other Medical Education	0	29,893,203	0.000000	1,336,655	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/11/2015 7:37 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)		39,987	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		39,987	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)		38,199	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)		6,326	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)		3,386	15.00
16.00	Nursery days (title V or XIX only)		2,435	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)		29,893,203	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)		29,893,203	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)		29,893,203	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)		747.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,729,128	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)		4,729,128	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D-1 Date/Time Prepared: 5/11/2015 7:37 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)	2,229,940	3,386	658.58	2,435	1,603,642	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,423,578	5,950	1,415.73	211	298,719	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)					6,631,489	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)					731,258	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)					731,258	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,900,231	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,788	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					747.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,336,655	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140084		Period: From 12/01/2013 To 11/30/2014		Worksheet D-1 Date/Time Prepared: 5/11/2015 7:37 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	3,864,180	29,893,203	0.129266	1,336,655	172,784	90.00
91.00	Nursing School cost	0	29,893,203	0.000000	1,336,655	0	91.00
92.00	Allied health cost	0	29,893,203	0.000000	1,336,655	0	92.00
93.00	All other Medical Education	0	29,893,203	0.000000	1,336,655	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet D-3 Date/Time Prepared: 5/11/2015 7:37 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		44,160,460	30.00
31.00	03100	INTENSIVE CARE UNIT		13,224,879	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.054369	45,019,566	2,447,669 50.00
51.00	05100	RECOVERY ROOM	0.148626	2,360,548	350,839 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.518977	25,002	12,975 52.00
53.00	05300	ANESTHESIOLOGY	0.081299	926,225	75,301 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.065936	29,993,104	1,977,625 54.00
54.01	05401	ULTRASOUND	0.000000	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MRI	0.000000	0	0 58.00
60.00	06000	LABORATORY	0.090429	31,718,362	2,868,260 60.00
65.00	06500	RESPIRATORY THERAPY	0.107802	8,035,082	866,198 65.00
66.00	06600	PHYSICAL THERAPY	0.245101	3,916,753	960,000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.065237	18,525,664	1,208,559 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.228811	2,863,998	655,314 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.224853	11,586,645	2,605,292 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.073505	48,431,852	3,559,983 73.00
74.00	07400	RENAL DIALYSIS	0.184922	2,330,710	431,000 74.00
76.00	03020	CARDIAC REHAB	0.000000	0	0 76.00
76.02	03951	GUI DANCE	1.113513	6,998	7,792 76.02
76.03	03952	WOUND CARE	0.000000	0	0 76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
91.00	09100	EMERGENCY	0.103911	13,642,116	1,417,566 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.288092	628,981	181,204 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		220,011,606	19,625,577 200.00
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)		220,011,606	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Date/Time Prepared: 5/11/2015 7:37 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	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)		26,605,556		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		5,321,111		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)		450,632		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		2,286,715		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		185.10		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Date/Time Prepared: 5/11/2015 7:37 am	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	2.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	1.01	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.35		30.00
31.00	Percentage of Medicaid patient days (see instructions)		31.29		31.00
32.00	Sum of lines 30 and 31		37.64		32.00
33.00	Allowable disproportionate share percentage (see instructions)		20.27		33.00
34.00	Disproportionate share adjustment (see instructions)		1,617,884		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,146	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000376231	0.000356729	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		3,403,529	2,728,138	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,834,721	455,935	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,290,656		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	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	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	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)		37,285,839		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)		37,285,839		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,865,879		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		40,151,718		59.00
60.00	Primary payer payments		52,850		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		40,098,868		61.00
62.00	Deductibles billed to program beneficiaries		3,448,544		62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Date/Time Prepared: 5/11/2015 7:37 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinsurance billed to program beneficiaries		146,400		63.00
64.00	Allowable bad debts (see instructions)		1,127,150		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		732,648		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		970,818		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		37,236,572		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)		5,983		70.93
70.94	HRR adjustment amount (see instructions)		-75,651		70.94
70.95	Recovery of accelerated depreciation		0		70.95
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)		37,166,904		71.00
71.01	Sequestration adjustment (see instructions)		743,338		71.01
72.00	Interim payments		35,740,482		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)		683,084		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,410,396		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part A Date/Time Prepared: 5/11/2015 7:37 am
		Title XVIII	Hospital	PPS
		Prior to 10/1		On/After 10/1
		1.00	1.01	2.00
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0		0
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0		0
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet E Part B Date/Time Prepared: 5/11/2015 7:37 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,886	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,035,416	2.00
3.00	PPS payments		10,805,440	3.00
4.00	Outlier payment (see instructions)		25,097	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)		2,886	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		39,267	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)		39,267	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)		39,267	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		36,381	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)		2,886	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)		10,830,537	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)		2,348,738	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)		8,484,685	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)		8,484,685	30.00
31.00	Primary payer payments		635	31.00
32.00	Subtotal (line 30 minus line 31)		8,484,050	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)		731,139	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		475,240	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		653,884	36.00
37.00	Subtotal (see instructions)		8,959,290	37.00
38.00	MSP-LCC reconciliation amount from PS&R		628	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)		8,958,662	40.00
40.01	Sequestration adjustment (see instructions)		179,173	40.01
41.00	Interim payments		8,906,872	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-127,383	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: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
5/11/2015 7:37 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		35,639,082		8,906,872	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	07/07/2014	101,400		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)		101,400		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)		35,740,482		8,906,872	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		683,084		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		127,383	6.02	
7.00	Total Medicare program liability (see instructions)		36,423,566		8,779,489	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: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet E-1
Part II
Date/Time Prepared:
5/11/2015 7:37 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			11,121 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			20,392 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,343 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			44,149 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1,095,659,668 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			18,021,680 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)			999,599 8.00
9.00	Sequestration adjustment amount (see instructions)			19,992 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			979,607 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,113,208 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)			-133,601 32.00

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

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet G

Date/Time Prepared:
5/11/2015 7:37 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	-2,181,691	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	58,303,324	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-17,027,039	0	0	0	6.00
7.00	Inventory	3,790,941	0	0	0	7.00
8.00	Prepaid expenses	1,429,865	0	0	0	8.00
9.00	Other current assets	1,371,530	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)	45,686,930	0	0	0	11.00
FIXED ASSETS						
12.00	Land	11,309,704	0	0	0	12.00
13.00	Land improvements	2,554,586	0	0	0	13.00
14.00	Accumulated depreciation	-1,042,138	0	0	0	14.00
15.00	Buildings	54,477,910	0	0	0	15.00
16.00	Accumulated depreciation	-10,774,615	0	0	0	16.00
17.00	Leasehold improvements	22,467,018	0	0	0	17.00
18.00	Accumulated depreciation	-4,934,208	0	0	0	18.00
19.00	Fixed equipment	4,623,802	0	0	0	19.00
20.00	Accumulated depreciation	-2,152,970	0	0	0	20.00
21.00	Automobiles and trucks	98,813	0	0	0	21.00
22.00	Accumulated depreciation	-90,640	0	0	0	22.00
23.00	Major movable equipment	25,095,003	0	0	0	23.00
24.00	Accumulated depreciation	-18,997,338	0	0	0	24.00
25.00	Minor equipment depreciable	17,981,536	0	0	0	25.00
26.00	Accumulated depreciation	-12,374,227	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)	88,242,236	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	14,959,890	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,959,890	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	148,889,056	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	27,181,138	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,625,988	0	0	0	38.00
39.00	Payroll taxes payable	652,047	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	91,099,686	0	0	0	43.00
44.00	Other current liabilities	3,334,569	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	127,893,428	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	127,893,428	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	20,995,628				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	20,995,628	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	148,889,056	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet G-1

Date/Time Prepared:
5/11/2015 7:37 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		17,893,772		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,101,862			2.00
3.00	Total (sum of line 1 and line 2)		20,995,634		0	3.00
4.00		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)		20,995,634		0	11.00
12.00	ROUNDING	6		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		6		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,995,628		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00			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	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/11/2015 7:37 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	100,484,858		100,484,858	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	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)	100,484,858		100,484,858	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	25,010,931		25,010,931	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)	25,010,931		25,010,931	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	125,495,789		125,495,789	17.00
18.00	Ancillary services	469,701,193	381,295,047	850,996,240	18.00
19.00	Outpatient services	32,194,374	86,973,265	119,167,639	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	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)	627,391,356	468,268,312	1,095,659,668	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		199,009,669		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)		199,009,669		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140084

Period:
From 12/01/2013
To 11/30/2014

Worksheet G-3

Date/Time Prepared:
5/11/2015 7:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,095,659,668	1.00
2.00	Less contractual allowances and discounts on patients' accounts	895,441,376	2.00
3.00	Net patient revenues (line 1 minus line 2)	200,218,292	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	199,009,669	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,208,623	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	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,893,239	24.00
25.00	Total other income (sum of lines 6-24)	1,893,239	25.00
26.00	Total (line 5 plus line 25)	3,101,862	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,101,862	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140084	Period: From 12/01/2013 To 11/30/2014	Worksheet L Parts I-III Date/Time Prepared: 5/11/2015 7:37 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,550,424	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		113,461	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)		121.82	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)		6.35	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		31.29	8.00
9.00	Sum of lines 7 and 8		37.64	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.92	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		201,994	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		2,865,879	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