

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: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/27/2015 12:00 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/27/2015	Time: 12:00 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVENTIST GLENOAKS HOSPITAL (140292) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	333,058	17,074	-14,652	0	1.00
2.00 Subprovider - IPF	0	30,024	-42		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	363,082	17,032	-14,652	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: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:56 am			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 701 WINTHROP AVENUE			PO Box:				1.00				
2.00	City: GLENDALE HEIGHTS			State: IL		Zip Code: 60139-		County: DUPAGE				
		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			ADVENTIST GLENOAKS HOSPITAL	140292	16974	1	11/23/1982	N	P	O	3.00
4.00	Subprovider - IPF			GLEN OAKS MED CTR PSYCH UNIT	14S292	16974	4	01/01/1984	N	P	T	4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2014		12/31/2014		20.00	
21.00	Type of Control (see instructions)						1				21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	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.			5,702	1,214	0	31	2,404	0			
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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:56 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	Y		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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted 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
				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.			Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			N	0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)				0	76.00
					1.00	
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00

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		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
				1.00	2.00
				3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	410,240	0		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: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:56 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	HF8013	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: ADVENTIST HEALTH SYSTEM	Contractor's Name: FIRST COAST SERVICE OPTIONS		Contractor's Number: 09001		141.00	
142.00	Street: 900 HOPE WAY	PO Box:		142.00			
143.00	City: ALTAMONTE SPRINGS	State: FL	Zip Code: 32714	143.00			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00			
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y		145.00			
				1.00			
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	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			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)			0.25			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:56 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)		10/01/2013	09/30/2014	170.00
			1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 11:56 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N			N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y		04/07/2015	Y
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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 11:56 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		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.	MI KE		THOMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVENTIST HEALTH SYSTEM SUNBELT			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	407-357-2338		MI KE. THOMPSON3@AHSS.ORG	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/07/2015	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT 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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 140292

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

Worksheet S-2
Part V
Date/Time Prepared:
5/27/2015 11:56 am

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	HARLIN	1.00
2.00	Last Name	THOMPSON	2.00
3.00	Title	REIMBURSEMENT MANAGER	3.00
4.00	Employer	ADVENTIST HEALTH SYSTEM SUNBELT, INC	4.00
5.00	Phone Number	(407)357-2338	5.00
6.00	E-mail Address	MIKE.THOMPSON3@AHSS.ORG	6.00
7.00	Department	CORPORATE REIMBURSEMENT	7.00
8.00	Mailing Address 1	900 HOPE WAY	8.00
9.00	Mailing Address 2		9.00
10.00	City	ALTAMONTE SPRING	10.00
11.00	State	FL	11.00
12.00	Zip	32714	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name		13.00
14.00	Last Name		14.00
15.00	Title		15.00
16.00	Employer		16.00
17.00	Phone Number		17.00
18.00	E-mail Address		18.00
19.00	Department		19.00
20.00	Mailing Address 1		20.00
21.00	Mailing Address 2		21.00
22.00	City		22.00
23.00	State		23.00
24.00	Zip		24.00

HFS Supplemental Information		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part IX Date/Time Prepared: 5/27/2015 11:56 am	
		Title V	Title XIX		
		1.00	2.00		
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00	
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00	
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00	
		Inpatient	Outpatient		
		1.00	2.00		
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00	
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00	
		Title V	Title XIX		
		1.00	2.00		
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00	
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140292

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2015 11:56 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	107	39,055	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)		107	39,055	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		117	42,705	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	16	5,840		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		133				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: 140292

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2015 11:56 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,983	4,714	20,871			1.00
2.00 HMO and other (see instructions)	599	3,650				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)	7,983	4,714	20,871			7.00
8.00 INTENSIVE CARE UNIT	1,140	171	2,194			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		759	910			13.00
14.00 Total (see instructions)	9,123	5,644	23,975	0.00	498.79	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	3,809	188	4,976	0.00	25.45	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	61			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	524.24	27.00
28.00 Observation Bed Days		472	2,142			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	57	82			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: 140292

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2015 11:56 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	1,446	1,340	4,859	1.00
2.00 HMO and other (see instructions)			127	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	1,446	1,340	4,859	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	262	10	373	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet S-3 Part II Date/Time Prepared: 5/27/2015 11:56 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	37,643,891	9,964	37,653,855	1,105,993.00	34.05	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		244,169	0	244,169	3,515.00	69.46	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		995,522	0	995,522	14,323.00	69.51	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,328,629	-260,945	6,067,684	193,653.00	31.33	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		24,302	0	24,302	139.82	173.81	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		3,822,186	0	3,822,186	54,992.00	69.50	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)		6,155,695	0	6,155,695			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,304,438	0	1,304,438			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		33,689	0	33,689			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	364,532	52,477	417,009	11,575.00	36.03	26.00
27.00	Administrative & General	5.00	5,409,777	-663,496	4,746,281	121,677.00	39.01	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	994,645	75,849	1,070,494	42,068.00	25.45	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	780,193	0	780,193	54,448.00	14.33	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	956,617	-301,399	655,218	38,806.00	16.88	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	301,399	301,399	17,855.00	16.88	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	965,160	260,420	1,225,580	28,700.00	42.70	38.00
39.00	Central Services and Supply	14.00	315,160	48,768	363,928	17,955.00	20.27	39.00
40.00	Pharmacy	15.00	1,339,603	0	1,339,603	30,793.00	43.50	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140292

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

Worksheet S-3
Part II
Date/Time Prepared:
5/27/2015 11:56 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 434,993	165,640	600,633	27,094.00	22.17	41.00
42.00	Social Service	17.00 738,215	0	738,215	19,311.00	38.23	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140292

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

Worksheet S-3
Part III
Date/Time Prepared:
5/27/2015 11:56 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	36,404,200	9,964	36,414,164	1,088,155.00	33.46	1.00
2.00	Excluded area salaries (see instructions)	6,328,629	-260,945	6,067,684	193,653.00	31.33	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30,075,571	270,909	30,346,480	894,502.00	33.93	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,846,488	0	3,846,488	55,131.82	69.77	4.00
5.00	Subtotal wage-related costs (see inst.)	6,155,695	0	6,155,695	0.00	20.28	5.00
6.00	Total (sum of lines 3 thru 5)	40,077,754	270,909	40,348,663	949,633.82	42.49	6.00
7.00	Total overhead cost (see instructions)	12,298,895	-60,342	12,238,553	410,282.00	29.83	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/27/2015 11:56 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		1,123,968	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)		3,177,126	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		27,640	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		443,442	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,503,161	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		76,856	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		142,629	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,494,822	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: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Prepared: 5/27/2015 11:56 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	6,674,822 1.00
2.00	Hospital		0	6,190,384 2.00
3.00	Subprovider - IPF		0	389,220 3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	95,218 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/27/2015 11:56 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)		0.262701	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		20,034,969	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,597,115	5.00	
6.00	Medicaid charges		72,583,440	6.00	
7.00	Medicaid cost (line 1 times line 6)		19,067,742	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)		0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		969,298	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		254,636	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)		254,636	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)		254,636	19.00	
			1.00		
			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	9,808,878	0	9,808,878	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,576,802	0	2,576,802	21.00
22.00	Partial payment by patients approved for charity care	3,520	0	3,520	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,573,282	0	2,573,282	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,251,083	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		556,949	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		2,694,134	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		707,752	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,281,034	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,535,670	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet A	Date/Time Prepared: 5/27/2015 11:56 am
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	0	0	3,157,487	3,157,487	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0	0	2,394,885	2,394,885	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	364,532	5,125,550	5,490,082	299,794	4.00
5.01 01160	COMMUNICATIONS	0	401,289	401,289	7,685	5.01
5.04 00570	ADMINISTRATIVE	724,583	536,651	1,261,234	-435	5.04
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	4,685,194	14,272,660	18,957,854	-1,584,596	5.06
7.00 00700	OPERATION OF PLANT	994,645	1,846,611	2,841,256	90,593	7.00
9.00 00900	HOUSEKEEPING	780,193	608,287	1,388,480	-1,140	9.00
10.00 01000	DIETARY	956,617	657,800	1,614,417	-512,334	10.00
11.00 01100	CAFETERIA	0	0	0	508,650	11.00
13.00 01300	NURSING ADMINISTRATION	965,160	137,089	1,102,249	334,063	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	315,160	80,083	395,243	146,615	14.00
15.00 01500	PHARMACY	1,339,603	2,464,622	3,804,225	-2,197,200	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	434,993	61,461	496,454	251,807	16.00
17.00 01700	SOCIAL SERVICE	738,215	239,217	977,432	-120	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,859,545	1,922,498	10,782,043	-1,070,903	30.00
31.00 03100	INTENSIVE CARE UNIT	1,812,543	374,631	2,187,174	-143,282	31.00
40.00 04000	SUBPROVIDER - I/PF	2,071,428	298,536	2,369,964	-285,965	40.00
43.00 04300	NURSERY	0	4,501	4,501	575,780	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,343,950	411,168	1,755,118	-18,908	50.00
51.00 05100	RECOVERY ROOM	238,336	21,812	260,148	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	584	584	923,243	52.00
53.00 05300	ANESTHESIOLOGY	45,633	36,750	82,383	-230	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	855,438	262,140	1,117,578	-1,044	54.00
56.00 05600	RADIOISOTOPE	154,504	122,472	276,976	-91,944	56.00
57.00 05700	CT SCAN	387,691	52,639	440,330	0	57.00
58.00 05800	MRI	162,775	21,130	183,905	-120	58.00
59.00 05900	CARDIAC CATHETERIZATION	490,397	429,145	919,542	-25,135	59.00
60.00 06000	LABORATORY	1,269,892	1,011,315	2,281,207	22,528	60.00
65.00 06500	RESPIRATORY THERAPY	632,024	173,718	805,742	-9,296	65.00
66.00 06600	PHYSICAL THERAPY	113	928,121	928,234	-73,981	66.00
67.00 06700	OCCUPATIONAL THERAPY	967	78,865	79,832	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	9,914	9,914	0	68.00
69.00 06900	ELECTROCARDIOLOGY	347,259	148,107	495,366	-1,012	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	18,927	16,966	35,893	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,320,544	1,320,544	94,769	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,339,823	2,339,823	4	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,987,897	73.00
74.00 07400	RENAL DIALYSIS	0	168,206	168,206	0	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01 03060	WOUND CARE	127,149	225,236	352,385	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	220,214	186,309	406,523	-30,221	90.00
91.00 09100	EMERGENCY	2,049,010	1,843,218	3,892,228	-2,823	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE		3,245,444	3,245,444	-4,745,111	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	33,386,690	42,085,112	75,471,802	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,404	14,786	45,190	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	136,017	7,114,844	7,250,861	0	192.00
192.03 19203	OP PHARMACY	146,563	247,953	394,516	0	192.03
194.00 07950	FOUNDATION	107,896	28,645	136,541	0	194.00
194.01 07951	MARKETING	146,470	410,802	557,272	0	194.01
194.03 07953	THERAPEUTIC DAY SCHOOL	3,689,851	1,343,761	5,033,612	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	37,643,891	51,245,903	88,889,794	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140292

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

Worksheet A
Date/Time Prepared:
5/27/2015 11:56 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	-731,321	2,426,166	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	131,831	2,526,716	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-47,014	5,742,862	4.00
5.01	01160	COMMUNICATIONS	-12,974	396,000	5.01
5.04	00570	ADMINISTRATIVE	-46	1,260,753	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-6,651,773	10,721,485	5.06
7.00	00700	OPERATION OF PLANT	-110,930	2,820,919	7.00
9.00	00900	HOUSEKEEPING	-471	1,386,869	9.00
10.00	01000	DIETARY	-130,392	971,691	10.00
11.00	01100	CAFETERIA	0	508,650	11.00
13.00	01300	NURSING ADMINISTRATION	-2,759	1,433,553	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	541,858	14.00
15.00	01500	PHARMACY	0	1,607,025	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,411	749,672	16.00
17.00	01700	SOCIAL SERVICE	0	977,312	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-485,697	9,225,443	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,705	2,042,187	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,083,999	40.00
43.00	04300	NURSERY	0	580,281	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,736,210	50.00
51.00	05100	RECOVERY ROOM	0	260,148	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-453	923,374	52.00
53.00	05300	ANESTHESIOLOGY	0	82,153	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-760	1,115,774	54.00
56.00	05600	RADIOISOTOPE	0	185,032	56.00
57.00	05700	CT SCAN	-246	440,084	57.00
58.00	05800	MRI	0	183,785	58.00
59.00	05900	CARDIAC CATHETERIZATION	-99,685	794,722	59.00
60.00	06000	LABORATORY	-756	2,302,979	60.00
65.00	06500	RESPIRATORY THERAPY	-3,669	792,777	65.00
66.00	06600	PHYSICAL THERAPY	0	854,253	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	79,832	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,914	68.00
69.00	06900	ELECTROCARDIOLOGY	-88,423	405,931	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-327	35,566	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-436,665	978,648	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,339,827	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-7,110	1,980,787	73.00
74.00	07400	RENAL DIALYSIS	0	168,206	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060	WOUND CARE	0	352,385	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-44,659	331,643	90.00
91.00	09100	EMERGENCY	-1,793,536	2,095,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	1,499,667	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,018,462	66,453,340	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	45,190	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,250,861	192.00
192.03	19203	OP PHARMACY	0	394,516	192.03
194.00	07950	FOUNDATION	0	136,541	194.00
194.01	07951	MARKETING	0	557,272	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	5,033,612	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-9,018,462	79,871,332	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140292

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

Worksheet Non-CMS W
Date/Time Prepared:
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Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01 COMMUNICATIONS	01160	COMMUNICATIONS	5.01
5.04 ADMITTING	00570	ADMITTING	5.04
5.06 OTHER ADMINISTRATIVE AND GENERAL	00560	PURCHASING RECEIVING AND STORES	5.06
7.00 OPERATION OF PLANT	00700		7.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
43.00 NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MRI	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
69.00 ELECTROCARDIOLOGY	06900		69.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
74.00 RENAL DIALYSIS	07400		74.00
76.00 BACTERIOLOGY & MICROBIOLOGY	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01 WOUND CARE	03060	BIOPSY	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	09000		90.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.03 OP PHARMACY	19203		192.03
194.00 FOUNDATION	07950		194.00
194.01 MARKETING	07951		194.01
194.03 THERAPEUTIC DAY SCHOOL	07953		194.03
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140292

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

Worksheet A-6
Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	100,957	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
	TOTALS		0	100,957	
B - CAFETERIA					
1.00	CAFETERIA	11.00	301,399	207,251	1.00
	TOTALS		301,399	207,251	
C - NURSERY					
1.00	NURSERY	43.00	422,715	153,065	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	672,976	250,267	2.00
	TOTALS		1,095,691	403,332	
D - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	183,393	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	467,433	2.00
3.00	COMMUNICATIONS	5.01	0	7,685	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
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	TOTALS		0	658,511	
E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,085,635	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,678,226	2.00
	TOTALS		0	2,763,861	
F - PSYCH ASSESSMENTS					
1.00	ADULTS & PEDIATRICS	30.00	260,945	24,300	1.00
	TOTALS		260,945	24,300	
G - CNO					
1.00	NURSING ADMINISTRATION	13.00	188,386	78,180	1.00
	TOTALS		188,386	78,180	
H - RECRUITMENT					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,400	0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	500	0	2.00
3.00	NURSING ADMINISTRATION	13.00	3,334	0	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	25	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	434	0	5.00
6.00	OPERATING ROOM	50.00	271	0	6.00
	TOTALS		9,964	0	
I - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	53,809	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,000	2.00
	TOTALS		0	56,809	
J - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,343	1.00
	TOTALS		0	11,343	

RECLASSIFICATIONS

Provider CCN: 140292

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

Worksheet A-6

Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
K - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,188	1.00
	TOTALS		0	6,188	
L - ROUTINE, ICU, PCU					
1.00	ADULTS & PEDIATRICS	30.00	0	167,984	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	24,812	2.00
	TOTALS		0	192,796	
M - SHARED SERVICES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	47,077	252,837	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	1,767,483	1,940,557	2.00
3.00	OPERATION OF PLANT	7.00	75,849	15,670	3.00
4.00	NURSING ADMINISTRATION	13.00	68,700	5,720	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	48,768	135,709	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	165,615	86,312	6.00
7.00	LABORATORY	60.00	69,601	49,894	7.00
	TOTALS		2,243,093	2,486,699	
N - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,823,307	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	246,226	2.00
	TOTALS		0	2,069,533	
O - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,197,200	1.00
	TOTALS		0	2,197,200	
500.00	Grand Total: Increases		4,099,478	11,256,960	500.00

RECLASSIFICATIONS

Provider CCN: 140292

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

Worksheet A-6
Date/Time Prepared:
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		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - BILLABLE SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	7	0	1.00
2.00	OPERATING ROOM	50.00	0	1,406	0	2.00
3.00	RADIOISOTOPE	56.00	0	91,944	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	302	0	4.00
5.00	LABORATORY	60.00	0	3	0	5.00
6.00	PHYSICAL THERAPY	66.00	0	603	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	0	508	0	7.00
8.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,184	0	8.00
	TOTALS		0	100,957		
B - CAFETERIA						
1.00	DIETARY	10.00	301,399	207,251	0	1.00
	TOTALS		301,399	207,251		
C - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	1,095,691	403,332	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		1,095,691	403,332		
D - RENT AND LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	120	10	1.00
2.00	EMERGENCY	91.00	0	2,823	10	2.00
3.00	ADMINISTRATIVE AND GENERAL	5.04	0	435	0	3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	139,843	0	4.00
5.00	OPERATION OF PLANT	7.00	0	926	0	5.00
6.00	HOUSEKEEPING	9.00	0	1,140	0	6.00
7.00	DIETARY	10.00	0	3,684	0	7.00
8.00	NURSING ADMINISTRATION	13.00	0	6,923	0	8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	37,862	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	120	0	10.00
11.00	SOCIAL SERVICE	17.00	0	120	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	0	290	0	12.00
13.00	INTENSIVE CARE UNIT	31.00	0	110	0	13.00
14.00	SUBPROVIDER - IPF	40.00	0	720	0	14.00
15.00	OPERATING ROOM	50.00	0	17,502	0	15.00
16.00	ANESTHESIOLOGY	53.00	0	230	0	16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,044	0	17.00
18.00	MRI	58.00	0	120	0	18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	24,833	0	19.00
20.00	LABORATORY	60.00	0	96,964	0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	9,296	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	73,378	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	504	0	23.00
24.00	DRUGS CHARGED TO PATIENTS	73.00	0	209,303	0	24.00
25.00	CLINIC	90.00	0	30,221	0	25.00
	TOTALS		0	658,511		
E - DEPRECIATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	99,626	9	1.00
2.00	INTEREST EXPENSE	113.00	0	2,664,235	9	2.00
	TOTALS		0	2,763,861		
F - PSYCH ASSESSMENTS						
1.00	SUBPROVIDER - IPF	40.00	260,945	24,300	0	1.00
	TOTALS		260,945	24,300		
G - CNO						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	188,386	78,180	0	1.00
	TOTALS		188,386	78,180		
H - RECRUITMENT						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,400	0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	500	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	3,334	0	3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	25	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	434	0	5.00
6.00	OPERATING ROOM	50.00	0	271	0	6.00
	TOTALS		0	9,964		
I - INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	56,809	12	1.00
2.00		0.00	0	0	12	2.00
	TOTALS		0	56,809		

RECLASSIFICATIONS

Provider CCN: 140292

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

Worksheet A-6

Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
J - PROPERTY TAX							
1.00	INTEREST EXPENSE	113.00	0	11,343	13		1.00
	TOTALS		0	11,343			
K - IMPLANTIBLES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,188	0		1.00
	TOTALS		0	6,188			
L - ROUTINE, ICU, PCU							
1.00	INTENSIVE CARE UNIT	31.00	0	167,984	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	24,812	0		2.00
	TOTALS		0	192,796			
M - SHARED SERVICES							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,243,093	2,486,699	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		2,243,093	2,486,699			
N - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	2,069,533	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	2,069,533			
O - BILLABLE DRUGS							
1.00	PHARMACY	15.00	0	2,197,200	0		1.00
	TOTALS		0	2,197,200			
500.00	Grand Total: Decreases		4,089,514	11,266,924			500.00

RECLASSIFICATIONS

Provider CCN: 140292

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/27/2015 11:56 am

Increases				Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - BILLABLE SUPPLIES								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	100,957	ADULTS & PEDIATRICS	30.00	0	7
2.00		0.00	0	0	OPERATING ROOM	50.00	0	1,406
3.00		0.00	0	0	RADIOISOTOPE	56.00	0	91,944
4.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	302
5.00		0.00	0	0	LABORATORY	60.00	0	3
6.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	603
7.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	508
8.00		0.00	0	0	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,184
	TOTALS		0	100,957	TOTALS		0	100,957
B - CAFETERIA								
1.00	CAFETERIA	11.00	301,399	207,251	DIETARY	10.00	301,399	207,251
	TOTALS		301,399	207,251	TOTALS		301,399	207,251
C - NURSERY								
1.00	NURSERY	43.00	422,715	153,065	ADULTS & PEDIATRICS	30.00	1,095,691	403,332
2.00	DELIVERY ROOM & LABOR ROOM	52.00	672,976	250,267		0.00	0	0
	TOTALS		1,095,691	403,332	TOTALS		1,095,691	403,332
D - RENT AND LEASES								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	183,393	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	120
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	467,433	EMERGENCY	91.00	0	2,823
3.00	COMMUNICATIONS	5.01	0	7,685	ADMINISTRATIVE AND GENERAL	5.04	0	435
4.00		0.00	0	0	OPERATION OF PLANT	5.06	0	139,843
5.00		0.00	0	0	HOUSEKEEPING	7.00	0	926
6.00		0.00	0	0	DIETARY	9.00	0	1,140
7.00		0.00	0	0	NURSING	10.00	0	3,684
8.00		0.00	0	0	ADMINISTRATIVE	13.00	0	6,923
9.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	37,862
10.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	120
11.00		0.00	0	0	SOCIAL SERVICE	17.00	0	120
12.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	290
13.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	110
14.00		0.00	0	0	SUBPROVIDER - I/PF	40.00	0	720
15.00		0.00	0	0	OPERATING ROOM	50.00	0	17,502
16.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	230
17.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	1,044
18.00		0.00	0	0	MRI	58.00	0	120
19.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	24,833
20.00		0.00	0	0	LABORATORY	60.00	0	96,964
21.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	9,296
22.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	73,378
23.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	504
24.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	209,303
25.00		0.00	0	0	CLINIC	90.00	0	30,221
	TOTALS		0	658,511	TOTALS		0	658,511
E - DEPRECIATION								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,085,635	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	99,626
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,678,226	INTEREST EXPENSE	113.00	0	2,664,235
	TOTALS		0	2,763,861	TOTALS		0	2,763,861
F - PSYCH ASSESSMENTS								
1.00	ADULTS & PEDIATRICS	30.00	260,945	24,300	SUBPROVIDER - I/PF	40.00	260,945	24,300
	TOTALS		260,945	24,300	TOTALS		260,945	24,300
G - CNO								
1.00	NURSING ADMINISTRATIVE	13.00	188,386	78,180	OTHER ADMINISTRATIVE AND GENERAL	5.06	188,386	78,180
	TOTALS		188,386	78,180	TOTALS		188,386	78,180
H - RECRUITMENT								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,400	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,400
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	500	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	500

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
3.00	NURSING	13.00	3,334		NURSING	13.00	0	3,334	3.00
4.00	ADMINISTRATION	16.00	25		ADMINISTRATION	16.00	0	25	4.00
5.00	MEDICAL RECORDS & LIBRARY	30.00	434		MEDICAL RECORDS & LIBRARY	30.00	0	434	5.00
6.00	ADULTS & PEDIATRICS OPERATING ROOM	50.00	271		ADULTS & PEDIATRICS OPERATING ROOM	50.00	0	271	6.00
	TOTALS		9,964		TOTALS		0	9,964	
I - INSURANCE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	53,809	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	56,809	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,000		0.00	0	0	2.00
	TOTALS		0	56,809	TOTALS		0	56,809	
J - PROPERTY TAX									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,343	INTEREST EXPENSE	113.00	0	11,343	1.00
	TOTALS		0	11,343	TOTALS		0	11,343	
K - IMPLANTIBLES									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,188	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,188	1.00
	TOTALS		0	6,188	TOTALS		0	6,188	
L - ROUTINE, ICU, PCU									
1.00	ADULTS & PEDIATRICS	30.00	0	167,984	INTENSIVE CARE UNIT	31.00	0	167,984	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	24,812	ADULTS & PEDIATRICS	30.00	0	24,812	2.00
	TOTALS		0	192,796	TOTALS		0	192,796	
M - SHARED SERVICES									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	47,077	252,837	OTHER ADMINISTRATIVE AND GENERAL	5.06	2,243,093	2,486,699	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	1,767,483	1,940,557		0.00	0	0	2.00
3.00	OPERATION OF PLANT	7.00	75,849	15,670		0.00	0	0	3.00
4.00	NURSING	13.00	68,700	5,720		0.00	0	0	4.00
5.00	ADMINISTRATION	14.00	48,768	135,709		0.00	0	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	16.00	165,615	86,312		0.00	0	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	60.00	69,601	49,894		0.00	0	0	7.00
	TOTALS		2,243,093	2,486,699	TOTALS		2,243,093	2,486,699	
N - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,823,307	INTEREST EXPENSE	113.00	0	2,069,533	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	246,226		0.00	0	0	2.00
	TOTALS		0	2,069,533	TOTALS		0	2,069,533	
O - BILLABLE DRUGS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,197,200	PHARMACY	15.00	0	2,197,200	1.00
	TOTALS		0	2,197,200	TOTALS		0	2,197,200	
500.00	Grand Total: Increases		4,099,478	11,256,960	Grand Total: Decreases		4,089,514	11,266,924	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140292

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

Worksheet A-7
Part I
Date/Time Prepared:
5/27/2015 11:56 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,869,112	0	0	0	1.00
2.00	Land Improvements	78,294	0	0	0	2.00
3.00	Buildings and Fixtures	25,052,853	2,162,349	0	2,162,349	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	7,215,982	171,837	0	171,837	5.00
6.00	Movable Equipment	11,951,203	2,264,395	0	2,264,395	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,167,444	4,598,581	0	4,598,581	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	46,167,444	4,598,581	0	4,598,581	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,869,112	0			1.00
2.00	Land Improvements	78,294	0			2.00
3.00	Buildings and Fixtures	26,822,408	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	7,355,288	0			5.00
6.00	Movable Equipment	14,102,660	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	50,227,762	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	50,227,762	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140292

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

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2015 11:56 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140292

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

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2015 11:56 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	34,216,241	0	34,216,241	0.741134	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,951,203	0	11,951,203	0.258866	0	2.00
3.00	Total (sum of lines 1-2)	46,167,444	0	46,167,444	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,128,944	183,393	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,913,134	467,433	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,042,078	650,826	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,060,018	53,809	2	0	2,426,166	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	143,149	3,000	0	0	2,526,716	2.00
3.00	Total (sum of lines 1-2)	1,203,167	56,809	2	0	4,952,882	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140292

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

Worksheet A-8

Date/Time Prepared:
5/27/2015 11:56 am

Line #	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		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-763,289	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-103,077	CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	A	-12,974	COMMUNICATIONS	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-17,459	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,128,170			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	1,487,243			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	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	MISC REVENUE	B	-46	ADMIN	5.04	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140292

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

Worksheet A-8

Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.01	MI SC REVENUE	B	-123,881	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.01
33.02	MI SC REVENUE	B	-93,471	OPERATION OF PLANT	7.00	0 33.02
33.03	MI SC REVENUE	B	-471	HOUSEKEEPING	9.00	0 33.03
33.04	MI SC REVENUE	B	-130,392	DIETARY	10.00	0 33.04
33.05	MI SC REVENUE	B	-4,481	MEDICAL RECORDS & LIBRARY	16.00	0 33.05
33.06	MI SC REVENUE	B	-137	ADULTS & PEDIATRICS	30.00	0 33.06
33.07	MI SC REVENUE	B	-760	RADIOLOGY-DIAGNOSTIC	54.00	0 33.07
33.08	MI SC REVENUE	B	-1,200	CARDIAC CATHETERIZATION	59.00	0 33.08
33.09	MI SC REVENUE	B	-210	LABORATORY	60.00	0 33.09
33.10	MI SC REVENUE	B	-1,976	DRUGS CHARGED TO PATIENTS	73.00	0 33.10
33.11	MI SC REVENUE	B	-42,856	CLINIC	90.00	0 33.11
33.12	MI SC REVENUE	B	-33,100	EMERGENCY	91.00	0 33.12
33.13	LEGAL	A	-138,130	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.13
33.14	LOBBYING	A	-43,829	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.14
33.15	HOSPITALISTS	A	-266,173	EMERGENCY	91.00	0 33.15
33.16	RECRUITMENT	A	-37,855	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.16
33.17	PROPERTY TAXES	A	-11,341	CAP REL COSTS-BLDG & FIXT	1.00	13 33.17
33.18	GAIN/LOSS ON SALE OF ASSET	A	-108,995	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.18
33.19	STATE ASSESSMENT TAX	A	-5,151,790	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 33.19
33.20	PHYSICIAN COLLECTION FEES	A	-37,389	ELECTROCARDIOLOGY	69.00	0 33.20
33.21	PHYSICIAN COLLECTION FEES	A	-1,803	CLINIC	90.00	0 33.21
33.22	HOSPICE	A	-453	DELIVERY ROOM & LABOR ROOM	52.00	0 33.22
33.23	HOSPICE	A	-246	CT SCAN	57.00	0 33.23
33.24	HOSPICE	A	-546	LABORATORY	60.00	0 33.24
33.25	HOSPICE	A	-3,669	RESPIRATORY THERAPY	65.00	0 33.25
33.26	HOSPICE	A	-68	ELECTROCARDIOLOGY	69.00	0 33.26
33.27	HOSPICE	A	-327	ELECTROENCEPHALOGRAPHY	70.00	0 33.27
33.28	HOSPICE	A	-192	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0 33.28
33.29	HOSPICE	A	-5,134	DRUGS CHARGED TO PATIENTS	73.00	0 33.29
33.30	HOSPICE	A	-894	EMERGENCY	91.00	0 33.30
33.32	HOSPICE	A	-50,310	ADULTS & PEDIATRICS	30.00	0 33.32
35.00	HOSPICE	A	-1,705	INTENSIVE CARE UNIT	31.00	0 35.00
37.00	MALPRACTICE	A	-410,240	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 37.00
38.00	SPECIAL EVENTS	A	-11,690	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 38.00
39.00	SPECIAL EVENTS	A	-11,038	OTHER ADMINISTRATIVE AND GENERAL	5.06	0 39.00
41.00	SPECIAL EVENTS	A	-2,759	NURSING ADMINISTRATION	13.00	0 41.00
42.00	NON ALLOW BORROWING	A	-564,511	INTEREST EXPENSE	113.00	0 42.00
43.00	SELF INSURED OFFSET	A	-186,668	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 43.00
44.00			0		0.00	0 44.00
45.00			0		0.00	0 45.00
46.00			0		0.00	0 46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,018,462			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: 140292

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

Worksheet A-8-1

Date/Time Prepared: 5/27/2015 11:56 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.06	OTHER ADMINISTRATIVE AND GEN	AHS SHARED SERVICES	4,729,792	4,959,911 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	AHS HOME OFFICE	43,309	0 2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	AHS HOME OFFICE	234,908	0 3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	AHS HOME OFFICE	223,333	34,134 4.00
4.01	5.06	OTHER ADMINISTRATIVE AND GEN	AHS HOME OFFICE	4,859,621	5,243,272 4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	AHS HOME OFFICE	7,212	1,320 4.02
4.03	71.00	MEDICAL SUPPLIES CHARGED TO	AHS HOME OFFICE	-425,630	10,843 4.03
4.04	113.00	INTEREST EXPENSE	AHS HOME OFFICE	2,629,832	565,654 4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,302,377	10,815,134 5.00

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

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

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

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

6.00	B	AHS CORPORATE	100.00	AHS CORPORATE	0.00	6.00
7.00	B	SHARED SERVICE	0.00	SHARED SERVICE	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 140292

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

Worksheet A-8-1

Date/Time Prepared:
5/27/2015 11:56 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	-230,119	0		1.00
2.00	43,309	9		2.00
3.00	234,908	9		3.00
4.00	189,199	0		4.00
4.01	-383,651	0		4.01
4.02	5,892	0		4.02
4.03	-436,473	0		4.03
4.04	2,064,178	0		4.04
5.00	1,487,243			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	MANAGEMENT SVCS		6.00
7.00	FINANCIAL SVCS		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: 140292

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

Worksheet A-8-2

Date/Time Prepared:
5/27/2015 11:56 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	91.00	EMERGENCY	244,169	244,169	0	0	0	1.00
2.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	50,100	50,100	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	435,250	435,250	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	98,485	98,485	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	50,966	50,966	0	0	0	5.00
6.00	91.00	EMERGENCY	1,249,200	1,249,200	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,128,170	2,128,170	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	244,169		1.00
2.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	50,100		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	435,250		3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	0	0	98,485		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	50,966		5.00
6.00	91.00	EMERGENCY	0	0	0	1,249,200		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,128,170		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT	2,426,166	2,426,166				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	2,526,716		2,526,716			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	5,742,862	7,415	7,722	5,757,999		4.00
5.01 01160 COMMUNICATIONS	396,000	3,603	3,752	0	403,355	5.01
5.04 00570 ADMITTING	1,260,753	11,870	12,362	112,044	0	5.04
5.06 00560 OTHER ADMINISTRATIVE AND GENERAL	10,721,485	84,928	88,448	621,883	295,215	5.06
7.00 00700 OPERATION OF PLANT	2,820,919	220,415	229,550	165,533	0	7.00
9.00 00900 HOUSEKEEPING	1,386,869	13,021	13,561	120,643	0	9.00
10.00 01000 DIETARY	971,691	58,408	60,828	101,318	0	10.00
11.00 01100 CAFETERIA	508,650	48,720	50,740	46,606	0	11.00
13.00 01300 NURSING ADMINISTRATION	1,433,553	13,230	13,779	189,514	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	541,858	64,836	67,523	56,275	0	14.00
15.00 01500 PHARMACY	1,607,025	23,411	24,381	207,145	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	749,672	19,898	20,722	92,877	0	16.00
17.00 01700 SOCIAL SERVICE	977,312	6,428	6,695	114,152	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	9,225,443	623,933	649,789	1,240,950	87,617	30.00
31.00 03100 INTENSIVE CARE UNIT	2,042,187	73,611	76,662	280,277	7,893	31.00
40.00 04000 SUBPROVIDER - IPF	2,083,999	88,576	92,247	279,959	12,630	40.00
43.00 04300 NURSERY	580,281	57,914	60,314	65,365	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,736,210	160,049	166,682	207,860	0	50.00
51.00 05100 RECOVERY ROOM	260,148	8,970	9,341	36,854	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	923,374	59,334	61,794	104,064	0	52.00
53.00 05300 ANESTHESIOLOGY	82,153	6,279	6,539	7,056	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,115,774	85,107	88,635	132,278	0	54.00
56.00 05600 RADIOISOTOPE	185,032	16,295	16,970	23,891	0	56.00
57.00 05700 CT SCAN	440,084	39,900	41,554	59,949	0	57.00
58.00 05800 MRI	183,785	19,853	20,676	25,170	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	794,722	36,985	38,518	75,831	0	59.00
60.00 06000 LABORATORY	2,302,979	63,834	66,480	207,128	0	60.00
65.00 06500 RESPIRATORY THERAPY	792,777	7,744	8,065	97,731	0	65.00
66.00 06600 PHYSICAL THERAPY	854,253	28,613	29,799	17	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	79,832	1,256	1,308	150	0	67.00
68.00 06800 SPEECH PATHOLOGY	9,914	822	856	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	405,931	33,651	35,046	53,697	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	35,566	4,216	4,390	2,927	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	978,648	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,339,827	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,980,787	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	168,206	0	0	0	0	74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01 03060 WOUND CARE	352,385	0	0	19,661	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	331,643	59,753	62,229	34,052	0	90.00
91.00 09100 EMERGENCY	2,095,869	289,392	301,386	316,843	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	66,453,340	2,342,270	2,439,343	5,099,700	403,355	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,190	4,111	4,281	4,701	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	7,250,861	0	0	21,033	0	192.00
192.03 19203 OP PHARMACY	394,516	5,232	5,449	22,663	0	192.03
194.00 07950 FOUNDATION	136,541	2,676	2,787	16,684	0	194.00
194.01 07951 MARKETING	557,272	3,558	3,705	22,649	0	194.01
194.03 07953 THERAPEUTIC DAY SCHOOL	5,033,612	68,319	71,151	570,569	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	79,871,332	2,426,166	2,526,716	5,757,999	403,355	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description			ADMINISTRATIVE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	
			5.04	5A.04	5.06	7.00	9.00	
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
5.01	01160	COMMUNICATIONS						5.01
5.04	00570	ADMINISTRATIVE	1,397,029					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	0	11,811,959	11,811,959			5.06
7.00	00700	OPERATION OF PLANT	0	3,436,417	596,404	4,032,821		7.00
9.00	00900	HOUSEKEEPING	0	1,534,094	266,248	25,030	1,825,372	9.00
10.00	01000	DIETARY	0	1,192,245	206,919	112,276	51,137	10.00
11.00	01100	CAFETERIA	0	654,716	113,629	93,654	42,655	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,650,076	286,377	25,432	11,583	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	730,492	126,780	124,633	56,765	14.00
15.00	01500	PHARMACY	0	1,861,962	323,151	45,002	20,497	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	883,169	153,278	38,249	17,421	16.00
17.00	01700	SOCIAL SERVICE	0	1,104,587	191,705	12,357	5,628	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	198,204	12,025,936	2,087,131	1,199,372	546,261	30.00
31.00	03100	INTENSIVE CARE UNIT	29,715	2,510,345	435,680	141,501	64,448	31.00
40.00	04000	SUBPROVIDER - IPF	43,965	2,601,376	451,479	170,267	77,549	40.00
43.00	04300	NURSERY	5,026	768,900	133,446	111,328	50,705	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	82,927	2,353,728	408,499	307,659	140,125	50.00
51.00	05100	RECOVERY ROOM	14,632	329,945	57,263	17,242	7,853	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,002	1,156,568	200,727	114,058	51,948	52.00
53.00	05300	ANESTHESIOLOGY	20,837	122,864	21,324	12,070	5,497	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,943	1,495,737	259,591	163,600	74,513	54.00
56.00	05600	RADIOISOTOPE	18,387	260,575	45,224	31,323	14,266	56.00
57.00	05700	CT SCAN	112,689	694,176	120,477	76,699	34,933	57.00
58.00	05800	MRI	26,165	275,649	47,840	38,163	17,382	58.00
59.00	05900	CARDIAC CATHETERIZATION	46,255	992,311	172,220	71,096	32,381	59.00
60.00	06000	LABORATORY	184,691	2,825,112	490,309	122,707	55,888	60.00
65.00	06500	RESPIRATORY THERAPY	36,620	942,937	163,650	14,886	6,780	65.00
66.00	06600	PHYSICAL THERAPY	19,821	932,503	161,840	55,003	25,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,925	84,471	14,660	2,414	1,099	67.00
68.00	06800	SPEECH PATHOLOGY	889	12,481	2,166	1,581	720	68.00
69.00	06900	ELECTROCARDIOLOGY	46,039	574,364	99,683	64,687	29,462	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,010	48,109	8,350	8,104	3,691	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,467	1,019,115	176,871	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,601	2,387,428	414,348	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	124,183	2,104,970	365,326	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,807	172,013	29,854	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	2,446	374,492	64,995	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,963	499,640	86,715	114,862	52,315	90.00
91.00	09100	EMERGENCY	194,820	3,198,310	555,079	556,293	253,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,397,029	65,623,772	9,339,238	3,871,548	1,751,920	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,283	10,115	7,903	3,599	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,271,894	1,262,066	0	0	192.00
192.03	19203	OP PHARMACY	0	427,860	74,257	10,058	4,581	192.03
194.00	07950	FOUNDATION	0	158,688	27,541	5,144	2,343	194.00
194.01	07951	MARKETING	0	587,184	101,908	6,839	3,115	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	5,743,651	996,834	131,329	59,814	194.03
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,397,029	79,871,332	11,811,959	4,032,821	1,825,372	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	1,562,577					10.00
11.00	01100	0	904,654				11.00
13.00	01300	0	28,175	2,001,643			13.00
14.00	01400	0	170,869	0	1,209,539		14.00
15.00	01500	0	31,310	0	0	2,281,922	15.00
16.00	01600	0	21,880	0	0	0	16.00
17.00	01700	0	19,644	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,163,028	240,893	981,839	68,748	0	30.00
31.00	03100	122,262	46,527	189,639	33,726	0	31.00
40.00	04000	277,287	54,228	221,026	11,330	0	40.00
43.00	04300	0	12,243	49,900	1,259	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	38,504	156,936	47,388	498	50.00
51.00	05100	0	5,533	22,554	1,334	0	51.00
52.00	05200	0	19,505	79,502	0	0	52.00
53.00	05300	0	2,121	8,646	5,171	0	53.00
54.00	05400	0	23,725	0	2,368	20	54.00
56.00	05600	0	3,435	0	26,183	310	56.00
57.00	05700	0	9,891	0	4,170	294	57.00
58.00	05800	0	3,943	0	133	14	58.00
59.00	05900	0	10,721	0	4,146	0	59.00
60.00	06000	0	43,945	0	8,490	0	60.00
65.00	06500	0	20,220	0	5,429	0	65.00
66.00	06600	0	0	0	1,130	1,258	66.00
67.00	06700	0	23	0	5	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	10,421	0	1,846	198	69.00
70.00	07000	0	784	0	200	0	70.00
71.00	07100	0	0	0	355,898	0	71.00
72.00	07200	0	0	0	556,237	0	72.00
73.00	07300	0	0	0	8,801	2,263,236	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	0	4,173	0	2,980	4,467	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	7,078	28,850	4,209	2,371	90.00
91.00	09100	0	64,465	262,751	58,358	9,256	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,562,577	894,256	2,001,643	1,209,539	2,281,922	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	1,660	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	2,444	0	0	0	192.03
194.00	07950	0	2,075	0	0	0	194.00
194.01	07951	0	4,219	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,562,577	904,654	2,001,643	1,209,539	2,281,922	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140292

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

Worksheet B
Part I
Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	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
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMINISTRATIVE					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
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	1,113,997				16.00
17.00	01700	SOCIAL SERVICE	0	1,333,921			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	158,062	958,919	19,430,189	0	19,430,189
31.00	03100	INTENSIVE CARE UNIT	23,695	100,803	3,668,626	0	3,668,626
40.00	04000	SUBPROVIDER - IPF	35,058	228,622	4,128,222	0	4,128,222
43.00	04300	NURSERY	4,008	41,810	1,173,599	0	1,173,599
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	66,126	0	3,519,463	0	3,519,463
51.00	05100	RECOVERY ROOM	11,667	0	453,391	0	453,391
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,381	3,767	1,632,456	0	1,632,456
53.00	05300	ANESTHESIOLOGY	16,616	0	194,309	0	194,309
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,962	0	2,078,516	0	2,078,516
56.00	05600	RADIOISOTOPE	14,661	0	395,977	0	395,977
57.00	05700	CT SCAN	89,857	0	1,030,497	0	1,030,497
58.00	05800	MRI	20,864	0	403,988	0	403,988
59.00	05900	CARDIAC CATHETERIZATION	36,883	0	1,319,758	0	1,319,758
60.00	06000	LABORATORY	147,272	0	3,693,723	0	3,693,723
65.00	06500	RESPIRATORY THERAPY	29,200	0	1,183,102	0	1,183,102
66.00	06600	PHYSICAL THERAPY	15,805	0	1,192,590	0	1,192,590
67.00	06700	OCCUPATIONAL THERAPY	1,535	0	104,207	0	104,207
68.00	06800	SPEECH PATHOLOGY	708	0	17,656	0	17,656
69.00	06900	ELECTROCARDIOLOGY	36,711	0	817,372	0	817,372
70.00	07000	ELECTROENCEPHALOGRAPHY	805	0	70,043	0	70,043
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,268	0	1,584,152	0	1,584,152
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,957	0	3,395,970	0	3,395,970
73.00	07300	DRUGS CHARGED TO PATIENTS	99,023	0	4,841,356	0	4,841,356
74.00	07400	RENAL DIALYSIS	3,036	0	204,903	0	204,903
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	1,950	0	453,057	0	453,057
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,539	0	805,579	0	805,579
91.00	09100	EMERGENCY	155,348	0	5,113,227	0	5,113,227
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,113,997	1,333,921	62,905,928	0	62,905,928
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	81,560	0	81,560
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	8,533,960	0	8,533,960
192.03	19203	OP PHARMACY	0	0	519,200	0	519,200
194.00	07950	FOUNDATION	0	0	195,791	0	195,791
194.01	07951	MARKETING	0	0	703,265	0	703,265
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	6,931,628	0	6,931,628
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,113,997	1,333,921	79,871,332	0	79,871,332

COST ALLOCATION STATISTICS

Provider CCN: 140292

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

Worksheet Non-CMS W
Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.01	COMMUNICATIONS	2	NUMBER OF PHONES	5.01
5.04	ADMITTING	C	GROSS CHARGES	5.04
5.06	OTHER ADMINISTRATIVE AND GENERAL	-1	ACCUM. COST	5.06
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	HOURS WORKED	11.00
13.00	NURSING ADMINISTRATION	5	DIRECT NRSING	13.00
14.00	CENTRAL SERVICES & SUPPLY	6	COSTED REQUIS.	14.00
15.00	PHARMACY	7	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	8	TOTAL PATIENT DAYS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140292

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2015 11:56 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	7,415	7,722	15,137	15,137 4.00
5.01 01160	COMMUNICATIONS	0	3,603	3,752	7,355	0 5.01
5.04 00570	ADMINISTRATIVE	0	11,870	12,362	24,232	295 5.04
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	0	84,928	88,448	173,376	1,637 5.06
7.00 00700	OPERATION OF PLANT	0	220,415	229,550	449,965	436 7.00
9.00 00900	HOUSEKEEPING	0	13,021	13,561	26,582	318 9.00
10.00 01000	DIETARY	0	58,408	60,828	119,236	267 10.00
11.00 01100	CAFETERIA	0	48,720	50,740	99,460	123 11.00
13.00 01300	NURSING ADMINISTRATION	0	13,230	13,779	27,009	499 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	64,836	67,523	132,359	148 14.00
15.00 01500	PHARMACY	0	23,411	24,381	47,792	545 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	19,898	20,722	40,620	244 16.00
17.00 01700	SOCIAL SERVICE	0	6,428	6,695	13,123	300 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	623,933	649,789	1,273,722	3,246 30.00
31.00 03100	INTENSIVE CARE UNIT	0	73,611	76,662	150,273	738 31.00
40.00 04000	SUBPROVIDER - IPF	0	88,576	92,247	180,823	737 40.00
43.00 04300	NURSERY	0	57,914	60,314	118,228	172 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	160,049	166,682	326,731	547 50.00
51.00 05100	RECOVERY ROOM	0	8,970	9,341	18,311	97 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	59,334	61,794	121,128	274 52.00
53.00 05300	ANESTHESIOLOGY	0	6,279	6,539	12,818	19 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	85,107	88,635	173,742	348 54.00
56.00 05600	RADIOISOTOPE	0	16,295	16,970	33,265	63 56.00
57.00 05700	CT SCAN	0	39,900	41,554	81,454	158 57.00
58.00 05800	MRI	0	19,853	20,676	40,529	66 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	36,985	38,518	75,503	200 59.00
60.00 06000	LABORATORY	0	63,834	66,480	130,314	545 60.00
65.00 06500	RESPIRATORY THERAPY	0	7,744	8,065	15,809	257 65.00
66.00 06600	PHYSICAL THERAPY	0	28,613	29,799	58,412	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,256	1,308	2,564	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	822	856	1,678	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	33,651	35,046	68,697	141 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	4,216	4,390	8,606	8 70.00
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 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0 76.00
76.01 03060	WOUND CARE	0	0	0	0	52 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	59,753	62,229	121,982	90 90.00
91.00 09100	EMERGENCY	0	289,392	301,386	590,778	834 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,342,270	2,439,343	4,781,613	13,404 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,111	4,281	8,392	12 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	55 192.00
192.03 19203	OP PHARMACY	0	5,232	5,449	10,681	60 192.03
194.00 07950	FOUNDATION	0	2,676	2,787	5,463	44 194.00
194.01 07951	MARKETING	0	3,558	3,705	7,263	60 194.01
194.03 07953	THERAPEUTIC DAY SCHOOL	0	68,319	71,151	139,470	1,502 194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	2,426,166	2,526,716	4,952,882	15,137 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/27/2015 11:56 am	
Cost Center Description			COMMUNICATIONS	ADMINITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	
			5.01	5.04	5.06	7.00	9.00	
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
5.01	01160	COMMUNICATIONS	7,355					5.01
5.04	00570	ADMINITTING	0	24,527				5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	5,383	0	180,396			5.06
7.00	00700	OPERATION OF PLANT	0	0	9,110	459,511		7.00
9.00	00900	HOUSEKEEPING	0	0	4,067	2,852	33,819	9.00
10.00	01000	DIETARY	0	0	3,161	12,793	947	10.00
11.00	01100	CAFETERIA	0	0	1,736	10,671	790	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,374	2,898	215	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,937	14,201	1,052	14.00
15.00	01500	PHARMACY	0	0	4,936	5,128	380	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	2,341	4,358	323	16.00
17.00	01700	SOCIAL SERVICE	0	0	2,928	1,408	104	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,598	3,565	31,848	136,660	10,123	30.00
31.00	03100	INTENSIVE CARE UNIT	144	520	6,655	16,123	1,194	31.00
40.00	04000	SUBPROVIDER - IPF	230	769	6,896	19,401	1,437	40.00
43.00	04300	NURSERY	0	88	2,038	12,685	939	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,450	6,240	35,056	2,596	50.00
51.00	05100	RECOVERY ROOM	0	256	875	1,965	145	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	140	3,066	12,996	962	52.00
53.00	05300	ANESTHESIOLOGY	0	364	326	1,375	102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,293	3,965	18,641	1,381	54.00
56.00	05600	RADIOISOTOPE	0	321	691	3,569	264	56.00
57.00	05700	CT SCAN	0	1,970	1,840	8,739	647	57.00
58.00	05800	MRI	0	457	731	4,348	322	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	809	2,631	8,101	600	59.00
60.00	06000	LABORATORY	0	3,229	7,489	13,982	1,035	60.00
65.00	06500	RESPIRATORY THERAPY	0	640	2,500	1,696	126	65.00
66.00	06600	PHYSICAL THERAPY	0	347	2,472	6,267	464	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	34	224	275	20	67.00
68.00	06800	SPEECH PATHOLOGY	0	16	33	180	13	68.00
69.00	06900	ELECTROCARDIOLOGY	0	805	1,523	7,371	546	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	18	128	923	68	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	708	2,702	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	832	6,329	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,171	5,580	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	67	456	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	43	993	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	209	1,325	13,088	969	90.00
91.00	09100	EMERGENCY	0	3,406	8,479	63,386	4,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,355	24,527	142,625	441,136	32,458	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	155	900	67	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	19,278	0	0	192.00
192.03	19203	OP PHARMACY	0	0	1,134	1,146	85	192.03
194.00	07950	FOUNDATION	0	0	421	586	43	194.00
194.01	07951	MARKETING	0	0	1,557	779	58	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	15,226	14,964	1,108	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,355	24,527	180,396	459,511	33,819	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/27/2015 11:56 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	136,404					10.00
11.00	01100	0	112,780				11.00
13.00	01300	0	3,512	38,507			13.00
14.00	01400	0	21,302	0	170,999		14.00
15.00	01500	0	3,903	0	0	62,684	15.00
16.00	01600	0	2,728	0	0	0	16.00
17.00	01700	0	2,449	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	101,525	30,031	18,889	9,719	0	30.00
31.00	03100	10,673	5,800	3,648	4,768	0	31.00
40.00	04000	24,206	6,760	4,252	1,602	0	40.00
43.00	04300	0	1,526	960	178	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	4,800	3,019	6,700	14	50.00
51.00	05100	0	690	434	189	0	51.00
52.00	05200	0	2,432	1,529	0	0	52.00
53.00	05300	0	264	166	731	0	53.00
54.00	05400	0	2,958	0	335	1	54.00
56.00	05600	0	428	0	3,702	9	56.00
57.00	05700	0	1,233	0	590	8	57.00
58.00	05800	0	492	0	19	0	58.00
59.00	05900	0	1,337	0	586	0	59.00
60.00	06000	0	5,478	0	1,200	0	60.00
65.00	06500	0	2,521	0	768	0	65.00
66.00	06600	0	0	0	160	35	66.00
67.00	06700	0	3	0	1	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	1,299	0	261	5	69.00
70.00	07000	0	98	0	28	0	70.00
71.00	07100	0	0	0	50,316	0	71.00
72.00	07200	0	0	0	78,636	0	72.00
73.00	07300	0	0	0	1,244	62,170	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	0	520	0	421	123	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	882	555	595	65	90.00
91.00	09100	0	8,037	5,055	8,250	254	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1-117)		136,404	111,483	38,507	170,999	62,684	
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	207	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	305	0	0	0	192.03
194.00	07950	0	259	0	0	0	194.00
194.01	07951	0	526	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00							202.00
TOTAL (sum lines 118-201)		136,404	112,780	38,507	170,999	62,684	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140292

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	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
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMINISTRATIVE					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
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	50,614				16.00
17.00	01700	SOCIAL SERVICE	0	20,312			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,255	14,602	1,642,783	0	1,642,783
31.00	03100	INTENSIVE CARE UNIT	1,075	1,535	203,146	0	203,146
40.00	04000	SUBPROVIDER - IPF	1,590	3,481	252,184	0	252,184
43.00	04300	NURSERY	182	637	137,633	0	137,633
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,999	0	390,152	0	390,152
51.00	05100	RECOVERY ROOM	529	0	23,491	0	23,491
52.00	05200	DELIVERY ROOM & LABOR ROOM	289	57	142,873	0	142,873
53.00	05300	ANESTHESIOLOGY	754	0	16,919	0	16,919
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,674	0	205,338	0	205,338
56.00	05600	RADIOISOTOPE	665	0	42,977	0	42,977
57.00	05700	CT SCAN	4,076	0	100,715	0	100,715
58.00	05800	MRI	946	0	47,910	0	47,910
59.00	05900	CARDIAC CATHETERIZATION	1,673	0	91,440	0	91,440
60.00	06000	LABORATORY	6,680	0	169,952	0	169,952
65.00	06500	RESPIRATORY THERAPY	1,324	0	25,641	0	25,641
66.00	06600	PHYSICAL THERAPY	717	0	68,874	0	68,874
67.00	06700	OCCUPATIONAL THERAPY	70	0	3,191	0	3,191
68.00	06800	SPEECH PATHOLOGY	32	0	1,952	0	1,952
69.00	06900	ELECTROCARDIOLOGY	1,665	0	82,313	0	82,313
70.00	07000	ELECTROENCEPHALOGRAPHY	37	0	9,914	0	9,914
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,464	0	55,190	0	55,190
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,722	0	87,519	0	87,519
73.00	07300	DRUGS CHARGED TO PATIENTS	4,491	0	75,656	0	75,656
74.00	07400	RENAL DIALYSIS	138	0	661	0	661
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	88	0	2,240	0	2,240
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	433	0	140,193	0	140,193
91.00	09100	EMERGENCY	7,046	0	700,219	0	700,219
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,614	20,312	4,721,076	0	4,721,076
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	9,733	0	9,733
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	19,333	0	19,333
192.03	19203	OP PHARMACY	0	0	13,411	0	13,411
194.00	07950	FOUNDATION	0	0	6,816	0	6,816
194.01	07951	MARKETING	0	0	10,243	0	10,243
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	172,270	0	172,270
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	50,614	20,312	4,952,882	0	4,952,882

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

Worksheet B-1

Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	162,291				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		162,291			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	496	496	37,236,846		4.00
5.01 01160	COMMUNICATIONS	241	241	0	511	5.01
5.04 00570	ADMITTING	794	794	724,583	0	239,458,291
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	5,681	5,681	4,021,698	374	0
7.00 00700	OPERATION OF PLANT	14,744	14,744	1,070,494	0	0
9.00 00900	HOUSEKEEPING	871	871	780,193	0	0
10.00 01000	DIETARY	3,907	3,907	655,218	0	0
11.00 01100	CAFETERIA	3,259	3,259	301,399	0	0
13.00 01300	NURSING ADMINISTRATION	885	885	1,225,580	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	4,337	4,337	363,928	0	0
15.00 01500	PHARMACY	1,566	1,566	1,339,603	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,331	1,331	600,633	0	0
17.00 01700	SOCIAL SERVICE	430	430	738,215	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	41,736	41,736	8,025,233	111	33,969,370
31.00 03100	INTENSIVE CARE UNIT	4,924	4,924	1,812,543	10	5,093,421
40.00 04000	SUBPROVIDER - IPF	5,925	5,925	1,810,483	16	7,536,080
43.00 04300	NURSERY	3,874	3,874	422,715	0	861,560
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	10,706	10,706	1,344,221	0	14,214,482
51.00 05100	RECOVERY ROOM	600	600	238,336	0	2,507,974
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,969	3,969	672,976	0	1,371,631
53.00 05300	ANESTHESIOLOGY	420	420	45,633	0	3,571,698
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,693	5,693	855,438	0	12,674,536
56.00 05600	RADIOISOTOPE	1,090	1,090	154,504	0	3,151,651
57.00 05700	CT SCAN	2,669	2,669	387,691	0	19,315,834
58.00 05800	MRI	1,328	1,328	162,775	0	4,484,875
59.00 05900	CARDIAC CATHETERIZATION	2,474	2,474	490,397	0	7,928,439
60.00 06000	LABORATORY	4,270	4,270	1,339,493	0	31,657,714
65.00 06500	RESPIRATORY THERAPY	518	518	632,024	0	6,276,927
66.00 06600	PHYSICAL THERAPY	1,914	1,914	113	0	3,397,466
67.00 06700	OCCUPATIONAL THERAPY	84	84	967	0	329,897
68.00 06800	SPEECH PATHOLOGY	55	55	0	0	152,297
69.00 06900	ELECTROCARDIOLOGY	2,251	2,251	347,259	0	7,891,453
70.00 07000	ELECTROENCEPHALOGRAPHY	282	282	18,927	0	173,075
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	6,936,392
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,159,277
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	21,286,128
74.00 07400	RENAL DIALYSIS	0	0	0	0	652,550
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01 03060	WOUND CARE	0	0	127,149	0	419,259
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,997	3,997	220,214	0	2,050,485
91.00 09100	EMERGENCY	19,358	19,358	2,049,010	0	33,393,820
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	156,679	156,679	32,979,645	511	239,458,291
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	275	275	30,404	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	136,017	0	0
192.03 19203	OP PHARMACY	350	350	146,563	0	0
194.00 07950	FOUNDATION	179	179	107,896	0	0
194.01 07951	MARKETING	238	238	146,470	0	0
194.03 07953	THERAPEUTIC DAY SCHOOL	4,570	4,570	3,689,851	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,426,166	2,526,716	5,757,999	403,355	1,397,029
203.00	Unit cost multiplier (Wkst. B, Part I)	14.949480	15.569046	0.154632	789.344423	0.005834
204.00	Cost to be allocated (per Wkst. B, Part II)			15,137	7,355	24,527
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000407	14.393346	0.000102

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

Worksheet B-1

Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5A.06	5.06	7.00	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
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMINISTRATIVE					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-11,811,959	68,059,373			5.06
7.00	00700	OPERATION OF PLANT	0	3,436,417	140,335		7.00
9.00	00900	HOUSEKEEPING	0	1,534,094	871	139,464	9.00
10.00	01000	DIETARY	0	1,192,245	3,907	3,907	288,789
11.00	01100	CAFETERIA	0	654,716	3,259	3,259	0
13.00	01300	NURSING ADMINISTRATION	0	1,650,076	885	885	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	730,492	4,337	4,337	0
15.00	01500	PHARMACY	0	1,861,962	1,566	1,566	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	883,169	1,331	1,331	0
17.00	01700	SOCIAL SERVICE	0	1,104,587	430	430	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	12,025,936	41,736	41,736	214,946
31.00	03100	INTENSIVE CARE UNIT	0	2,510,345	4,924	4,924	22,596
40.00	04000	SUBPROVIDER - IPF	0	2,601,376	5,925	5,925	51,247
43.00	04300	NURSERY	0	768,900	3,874	3,874	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,353,728	10,706	10,706	0
51.00	05100	RECOVERY ROOM	0	329,945	600	600	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,156,568	3,969	3,969	0
53.00	05300	ANESTHESIOLOGY	0	122,864	420	420	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,495,737	5,693	5,693	0
56.00	05600	RADIOISOTOPE	0	260,575	1,090	1,090	0
57.00	05700	CT SCAN	0	694,176	2,669	2,669	0
58.00	05800	MRI	0	275,649	1,328	1,328	0
59.00	05900	CARDIAC CATHETERIZATION	0	992,311	2,474	2,474	0
60.00	06000	LABORATORY	0	2,825,112	4,270	4,270	0
65.00	06500	RESPIRATORY THERAPY	0	942,937	518	518	0
66.00	06600	PHYSICAL THERAPY	0	932,503	1,914	1,914	0
67.00	06700	OCCUPATIONAL THERAPY	0	84,471	84	84	0
68.00	06800	SPEECH PATHOLOGY	0	12,481	55	55	0
69.00	06900	ELECTROCARDIOLOGY	0	574,364	2,251	2,251	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	48,109	282	282	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,019,115	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,387,428	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,104,970	0	0	0
74.00	07400	RENAL DIALYSIS	0	172,013	0	0	0
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	0	374,492	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	499,640	3,997	3,997	0
91.00	09100	EMERGENCY	0	3,198,310	19,358	19,358	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-11,811,959	53,811,813	134,723	133,852	288,789
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,283	275	275	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,271,894	0	0	0
192.03	19203	OP PHARMACY	0	427,860	350	350	0
194.00	07950	FOUNDATION	0	158,688	179	179	0
194.01	07951	MARKETING	0	587,184	238	238	0
194.03	07953	THERAPEUTIC DAY SCHOOL	0	5,743,651	4,570	4,570	0
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)		11,811,959	4,032,821	1,825,372	1,562,577
203.00		Unit cost multiplier (Wkst. B, Part I)		0.173554	28.737101	13.088482	5.410791
204.00		Cost to be allocated (per Wkst. B, Part II)		180,396	459,511	33,819	136,404
205.00		Unit cost multiplier (Wkst. B, Part II)		0.002651	3.274386	0.242493	0.472331

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140292

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

Worksheet B-1

Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description		CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		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
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	39,237					11.00
13.00	01300	1,222	21,300				13.00
14.00	01400	7,411	0	4,324,088			14.00
15.00	01500	1,358	0	0	2,168,696		15.00
16.00	01600	949	0	0	0	239,458,291	16.00
17.00	01700	852	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,448	10,448	245,772	0	33,969,370	30.00
31.00	03100	2,018	2,018	120,569	0	5,093,421	31.00
40.00	04000	2,352	2,352	40,506	0	7,536,080	40.00
43.00	04300	531	531	4,501	0	861,560	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,670	1,670	169,413	473	14,214,482	50.00
51.00	05100	240	240	4,768	0	2,507,974	51.00
52.00	05200	846	846	0	0	1,371,631	52.00
53.00	05300	92	92	18,487	0	3,571,698	53.00
54.00	05400	1,029	0	8,465	19	12,674,536	54.00
56.00	05600	149	0	93,605	295	3,151,651	56.00
57.00	05700	429	0	14,907	279	19,315,834	57.00
58.00	05800	171	0	476	13	4,484,875	58.00
59.00	05900	465	0	14,821	0	7,928,439	59.00
60.00	06000	1,906	0	30,353	0	31,657,714	60.00
65.00	06500	877	0	19,410	0	6,276,927	65.00
66.00	06600	0	0	4,041	1,196	3,397,466	66.00
67.00	06700	1	0	19	0	329,897	67.00
68.00	06800	0	0	0	0	152,297	68.00
69.00	06900	452	0	6,599	188	7,891,453	69.00
70.00	07000	34	0	715	0	173,075	70.00
71.00	07100	0	0	1,272,332	0	6,936,392	71.00
72.00	07200	0	0	1,988,534	0	8,159,277	72.00
73.00	07300	0	0	31,465	2,150,938	21,286,128	73.00
74.00	07400	0	0	0	0	652,550	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	181	0	10,654	4,245	419,259	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	307	307	15,047	2,253	2,050,485	90.00
91.00	09100	2,796	2,796	208,629	8,797	33,393,820	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		38,786	21,300	4,324,088	2,168,696	239,458,291	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	72	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	106	0	0	0	0	192.03
194.00	07950	90	0	0	0	0	194.00
194.01	07951	183	0	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		904,654	2,001,643	1,209,539	2,281,922	1,113,997	202.00
203.00		23,056,146	93,973,850	0,279,721	1,052,209	0,004,652	203.00
204.00		112,780	38,507	170,999	62,684	50,614	204.00
205.00		2,874,328	1,807,840	0,039,546	0,028,904	0,000,211	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 11:56 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		19,430,189	0	19,430,189	30.00
31.00	03100 INTENSIVE CARE UNIT		3,668,626	0	3,668,626	31.00
40.00	04000 SUBPROVIDER - I/PF		4,128,222	0	4,128,222	40.00
43.00	04300 NURSERY		1,173,599	0	1,173,599	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		3,519,463	0	3,519,463	50.00
51.00	05100 RECOVERY ROOM		453,391	0	453,391	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,632,456	0	1,632,456	52.00
53.00	05300 ANESTHESIOLOGY		194,309	0	194,309	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,078,516	0	2,078,516	54.00
56.00	05600 RADIOISOTOPE		395,977	0	395,977	56.00
57.00	05700 CT SCAN		1,030,497	0	1,030,497	57.00
58.00	05800 MRI		403,988	0	403,988	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,319,758	0	1,319,758	59.00
60.00	06000 LABORATORY		3,693,723	0	3,693,723	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,183,102	0	1,183,102	65.00
66.00	06600 PHYSICAL THERAPY	0	1,192,590	0	1,192,590	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	104,207	0	104,207	67.00
68.00	06800 SPEECH PATHOLOGY	0	17,656	0	17,656	68.00
69.00	06900 ELECTROCARDIOLOGY		817,372	0	817,372	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		70,043	0	70,043	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1,584,152	0	1,584,152	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,395,970	0	3,395,970	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,841,356	0	4,841,356	73.00
74.00	07400 RENAL DIALYSIS		204,903	0	204,903	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY		0	0	0	76.00
76.01	03060 WOUND CARE		453,057	0	453,057	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		805,579	0	805,579	90.00
91.00	09100 EMERGENCY		5,113,227	0	5,113,227	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,808,512	0	1,808,512	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		64,714,440	0	64,714,440	200.00
201.00	Less Observation Beds		1,808,512		1,808,512	201.00
202.00	Total (see instructions)		62,905,928	0	62,905,928	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2015 11:56 am

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	29,954,642		29,954,642		30.00
31.00	03100	INTENSIVE CARE UNIT	5,093,421		5,093,421		31.00
40.00	04000	SUBPROVIDER - IPF	7,536,080		7,536,080		40.00
43.00	04300	NURSERY	861,560		861,560		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,232,958	8,981,524	14,214,482	0.247597	50.00
51.00	05100	RECOVERY ROOM	691,355	1,816,619	2,507,974	0.180780	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,239,300	132,331	1,371,631	1.190157	52.00
53.00	05300	ANESTHESIOLOGY	1,370,112	2,201,586	3,571,698	0.054402	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,255,563	9,418,973	12,674,536	0.163991	54.00
56.00	05600	RADIOISOTOPE	1,020,381	2,131,270	3,151,651	0.125641	56.00
57.00	05700	CT SCAN	5,858,291	13,457,543	19,315,834	0.053350	57.00
58.00	05800	MRI	1,284,050	3,200,825	4,484,875	0.090078	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,952,060	2,976,379	7,928,439	0.166459	59.00
60.00	06000	LABORATORY	18,032,671	13,625,043	31,657,714	0.116677	60.00
65.00	06500	RESPIRATORY THERAPY	5,718,737	558,190	6,276,927	0.188484	65.00
66.00	06600	PHYSICAL THERAPY	661,682	2,735,784	3,397,466	0.351023	66.00
67.00	06700	OCCUPATIONAL THERAPY	298,090	31,807	329,897	0.315877	67.00
68.00	06800	SPEECH PATHOLOGY	143,806	8,491	152,297	0.115931	68.00
69.00	06900	ELECTROCARDIOLOGY	4,065,803	3,825,650	7,891,453	0.103577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,285	33,790	173,075	0.404697	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,242,809	3,693,583	6,936,392	0.228383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,331,302	3,827,975	8,159,277	0.416210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,910,265	7,375,863	21,286,128	0.227442	73.00
74.00	07400	RENAL DIALYSIS	652,550	0	652,550	0.314004	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE	0	419,259	419,259	1.080614	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,540	2,043,945	2,050,485	0.392872	90.00
91.00	09100	EMERGENCY	7,252,545	26,141,275	33,393,820	0.153119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	644,012	3,370,716	4,014,728	0.450469	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	127,449,870	112,008,421	239,458,291		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	127,449,870	112,008,421	239,458,291		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 11:56 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
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.247597		50.00
51.00	05100 RECOVERY ROOM	0.180780		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.190157		52.00
53.00	05300 ANESTHESIOLOGY	0.054402		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.163991		54.00
56.00	05600 RADIOISOTOPE	0.125641		56.00
57.00	05700 CT SCAN	0.053350		57.00
58.00	05800 MRI	0.090078		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.166459		59.00
60.00	06000 LABORATORY	0.116677		60.00
65.00	06500 RESPIRATORY THERAPY	0.188484		65.00
66.00	06600 PHYSICAL THERAPY	0.351023		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.315877		67.00
68.00	06800 SPEECH PATHOLOGY	0.115931		68.00
69.00	06900 ELECTROCARDIOLOGY	0.103577		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.404697		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228383		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416210		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.227442		73.00
74.00	07400 RENAL DIALYSIS	0.314004		74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000		76.00
76.01	03060 WOUND CARE	1.080614		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.392872		90.00
91.00	09100 EMERGENCY	0.153119		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.450469		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 11:56 am
		Title XIX	Hospital	Cost

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		19,430,189	0	19,430,189	30.00
31.00	03100 INTENSIVE CARE UNIT		3,668,626	0	3,668,626	31.00
40.00	04000 SUBPROVIDER - I/PF		4,128,222	0	4,128,222	40.00
43.00	04300 NURSERY		1,173,599	0	1,173,599	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		3,519,463	0	3,519,463	50.00
51.00	05100 RECOVERY ROOM		453,391	0	453,391	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,632,456	0	1,632,456	52.00
53.00	05300 ANESTHESIOLOGY		194,309	0	194,309	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,078,516	0	2,078,516	54.00
56.00	05600 RADIOISOTOPE		395,977	0	395,977	56.00
57.00	05700 CT SCAN		1,030,497	0	1,030,497	57.00
58.00	05800 MRI		403,988	0	403,988	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,319,758	0	1,319,758	59.00
60.00	06000 LABORATORY		3,693,723	0	3,693,723	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,183,102	0	1,183,102	65.00
66.00	06600 PHYSICAL THERAPY	0	1,192,590	0	1,192,590	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	104,207	0	104,207	67.00
68.00	06800 SPEECH PATHOLOGY	0	17,656	0	17,656	68.00
69.00	06900 ELECTROCARDIOLOGY		817,372	0	817,372	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		70,043	0	70,043	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1,584,152	0	1,584,152	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,395,970	0	3,395,970	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,841,356	0	4,841,356	73.00
74.00	07400 RENAL DIALYSIS		204,903	0	204,903	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY		0	0	0	76.00
76.01	03060 WOUND CARE		453,057	0	453,057	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		805,579	0	805,579	90.00
91.00	09100 EMERGENCY		5,113,227	0	5,113,227	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,808,512	0	1,808,512	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		64,714,440	0	64,714,440	200.00
201.00	Less Observation Beds		1,808,512		1,808,512	201.00
202.00	Total (see instructions)		62,905,928	0	62,905,928	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140292

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2015 11:56 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,954,642		29,954,642		30.00
31.00	03100	INTENSIVE CARE UNIT	5,093,421		5,093,421		31.00
40.00	04000	SUBPROVIDER - IPF	7,536,080		7,536,080		40.00
43.00	04300	NURSERY	861,560		861,560		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,232,958	8,981,524	14,214,482	0.247597	50.00
51.00	05100	RECOVERY ROOM	691,355	1,816,619	2,507,974	0.180780	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,239,300	132,331	1,371,631	1.190157	52.00
53.00	05300	ANESTHESIOLOGY	1,370,112	2,201,586	3,571,698	0.054402	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,255,563	9,418,973	12,674,536	0.163991	54.00
56.00	05600	RADIOISOTOPE	1,020,381	2,131,270	3,151,651	0.125641	56.00
57.00	05700	CT SCAN	5,858,291	13,457,543	19,315,834	0.053350	57.00
58.00	05800	MRI	1,284,050	3,200,825	4,484,875	0.090078	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,952,060	2,976,379	7,928,439	0.166459	59.00
60.00	06000	LABORATORY	18,032,671	13,625,043	31,657,714	0.116677	60.00
65.00	06500	RESPIRATORY THERAPY	5,718,737	558,190	6,276,927	0.188484	65.00
66.00	06600	PHYSICAL THERAPY	661,682	2,735,784	3,397,466	0.351023	66.00
67.00	06700	OCCUPATIONAL THERAPY	298,090	31,807	329,897	0.315877	67.00
68.00	06800	SPEECH PATHOLOGY	143,806	8,491	152,297	0.115931	68.00
69.00	06900	ELECTROCARDIOLOGY	4,065,803	3,825,650	7,891,453	0.103577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,285	33,790	173,075	0.404697	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,242,809	3,693,583	6,936,392	0.228383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,331,302	3,827,975	8,159,277	0.416210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,910,265	7,375,863	21,286,128	0.227442	73.00
74.00	07400	RENAL DIALYSIS	652,550	0	652,550	0.314004	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE	0	419,259	419,259	1.080614	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,540	2,043,945	2,050,485	0.392872	90.00
91.00	09100	EMERGENCY	7,252,545	26,141,275	33,393,820	0.153119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	644,012	3,370,716	4,014,728	0.450469	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	127,449,870	112,008,421	239,458,291		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	127,449,870	112,008,421	239,458,291		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/27/2015 11:56 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		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
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000		76.00
76.01	03060 WOUND CARE	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/27/2015 11:56 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,642,783	0	1,642,783	23,013	71.38	30.00
31.00	INTENSIVE CARE UNIT	203,146	0	203,146	2,194	92.59	31.00
40.00	SUBPROVIDER - IPF	252,184	0	252,184	4,976	50.68	40.00
43.00	NURSERY	137,633		137,633	910	151.25	43.00
200.00	Total (lines 30-199)	2,235,746		2,235,746	31,093		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	7,983	569,827				
31.00	INTENSIVE CARE UNIT	1,140	105,553				
40.00	SUBPROVIDER - IPF	3,809	193,040				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	12,932	868,420				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/27/2015 11:56 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	
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	390,152	14,214,482	0.027448	2,165,764	59,446	50.00
51.00	05100	RECOVERY ROOM	23,491	2,507,974	0.009367	212,257	1,988	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	142,873	1,371,631	0.104163	7,294	760	52.00
53.00	05300	ANESTHESIOLOGY	16,919	3,571,698	0.004737	357,316	1,693	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,338	12,674,536	0.016201	1,558,326	25,246	54.00
56.00	05600	RADIOISOTOPE	42,977	3,151,651	0.013636	482,401	6,578	56.00
57.00	05700	CT SCAN	100,715	19,315,834	0.005214	2,343,609	12,220	57.00
58.00	05800	MRI	47,910	4,484,875	0.010683	343,806	3,673	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,440	7,928,439	0.011533	1,153,010	13,298	59.00
60.00	06000	LABORATORY	169,952	31,657,714	0.005368	7,266,955	39,009	60.00
65.00	06500	RESPIRATORY THERAPY	25,641	6,276,927	0.004085	2,630,492	10,746	65.00
66.00	06600	PHYSICAL THERAPY	68,874	3,397,466	0.020272	313,895	6,363	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,191	329,897	0.009673	139,922	1,353	67.00
68.00	06800	SPEECH PATHOLOGY	1,952	152,297	0.012817	93,309	1,196	68.00
69.00	06900	ELECTROCARDIOLOGY	82,313	7,891,453	0.010431	1,721,160	17,953	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,914	173,075	0.057282	59,592	3,414	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,190	6,936,392	0.007957	1,203,974	9,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,519	8,159,277	0.010726	1,174,906	12,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,656	21,286,128	0.003554	5,910,828	21,007	73.00
74.00	07400	RENAL DIALYSIS	661	652,550	0.001013	389,727	395	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060	WOUND CARE	2,240	419,259	0.005343	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	140,193	2,050,485	0.068371	0	0	90.00
91.00	09100	EMERGENCY	700,219	33,393,820	0.020969	2,437,166	51,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	152,906	4,014,728	0.038086	388,350	14,791	92.00
200.00		Total (Lines 50-199)	2,638,236	196,012,588		32,354,059	314,416	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part III Date/Time Prepared: 5/27/2015 11:56 am
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Cost Center Description			Title XVIII				Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)			
			1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	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)	PSA Adj. Nursing School			
			6.00	7.00	8.00	9.00	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	23,013	0.00	7,983	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,194	0.00	1,140	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	4,976	0.00	3,809	0	0	0	0	40.00
43.00	04300	NURSERY	910	0.00	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	31,093		12,932	0	0	0	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost						
			12.00	13.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0	0						31.00
40.00	04000	SUBPROVIDER - IPF	0	0						40.00
43.00	04300	NURSERY	0	0						43.00
200.00		Total (lines 30-199)	0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
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Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140292

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2015 11:56 am

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	14,214,482	0.000000	0.000000	2,165,764	50.00
51.00	05100	RECOVERY ROOM	0	2,507,974	0.000000	0.000000	212,257	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,371,631	0.000000	0.000000	7,294	52.00
53.00	05300	ANESTHESIOLOGY	0	3,571,698	0.000000	0.000000	357,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,674,536	0.000000	0.000000	1,558,326	54.00
56.00	05600	RADIOISOTOPE	0	3,151,651	0.000000	0.000000	482,401	56.00
57.00	05700	CT SCAN	0	19,315,834	0.000000	0.000000	2,343,609	57.00
58.00	05800	MRI	0	4,484,875	0.000000	0.000000	343,806	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,928,439	0.000000	0.000000	1,153,010	59.00
60.00	06000	LABORATORY	0	31,657,714	0.000000	0.000000	7,266,955	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,276,927	0.000000	0.000000	2,630,492	65.00
66.00	06600	PHYSICAL THERAPY	0	3,397,466	0.000000	0.000000	313,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	329,897	0.000000	0.000000	139,922	67.00
68.00	06800	SPEECH PATHOLOGY	0	152,297	0.000000	0.000000	93,309	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,891,453	0.000000	0.000000	1,721,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	173,075	0.000000	0.000000	59,592	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,936,392	0.000000	0.000000	1,203,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,159,277	0.000000	0.000000	1,174,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,286,128	0.000000	0.000000	5,910,828	73.00
74.00	07400	RENAL DIALYSIS	0	652,550	0.000000	0.000000	389,727	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03060	WOUND CARE	0	419,259	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,050,485	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	33,393,820	0.000000	0.000000	2,437,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,014,728	0.000000	0.000000	388,350	92.00
200.00		Total (Lines 50-199)	0	196,012,588			32,354,059	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	2,712,804	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	575,937	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	243	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	608,267	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,409,819	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	728,529	0	0	0	56.00
57.00	05700 CT SCAN	0	2,729,471	0	0	0	57.00
58.00	05800 MRI	0	666,875	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	665,977	0	0	0	59.00
60.00	06000 LABORATORY	0	1,811,134	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	159,266	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	921,928	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	11,686	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,078,034	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,252,149	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,070,830	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	93,191	0	0	0	90.00
91.00	09100 EMERGENCY	0	2,913,423	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	845,993	0	0	0	92.00
200.00	Total (Lines 50-199)	0	22,255,556	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
	Title XVIII	Hospital	PPS

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
		23.00	24.00	
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
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
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 11:56 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	0.247597	2,712,804	0	0	671,682 50.00
51.00	05100 RECOVERY ROOM	0.180780	575,937	0	0	104,118 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.190157	243	0	0	289 52.00
53.00	05300 ANESTHESIOLOGY	0.054402	608,267	0	0	33,091 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.163991	1,409,819	0	0	231,198 54.00
56.00	05600 RADIOISOTOPE	0.125641	728,529	0	0	91,533 56.00
57.00	05700 CT SCAN	0.053350	2,729,471	0	0	145,617 57.00
58.00	05800 MRI	0.090078	666,875	0	0	60,071 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.166459	665,977	0	0	110,858 59.00
60.00	06000 LABORATORY	0.116677	1,811,134	0	0	211,318 60.00
65.00	06500 RESPIRATORY THERAPY	0.188484	159,266	0	0	30,019 65.00
66.00	06600 PHYSICAL THERAPY	0.351023	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.315877	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.115931	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.103577	921,928	0	0	95,491 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.404697	11,686	0	0	4,729 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228383	1,078,034	0	0	246,205 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416210	1,252,149	0	0	521,157 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.227442	3,070,830	123	30,104	698,436 73.00
74.00	07400 RENAL DIALYSIS	0.314004	0	0	0	0 74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0 76.00
76.01	03060 WOUND CARE	1.080614	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.392872	93,191	0	0	36,612 90.00
91.00	09100 EMERGENCY	0.153119	2,913,423	0	0	446,100 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.450469	845,993	0	0	381,094 92.00
200.00	Subtotal (see instructions)		22,255,556	123	30,104	4,119,618 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		22,255,556	123	30,104	4,119,618 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 11:56 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
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
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
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	28	6,847		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0	0		76.00
76.01 03060 WOUND CARE	0	0		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	28	6,847		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	28	6,847		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/27/2015 11:56 am	
		Component CCN: 14S292		Title XVIII		Subprovider - IPF	
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	390,152	14,214,482	0.027448	0	50.00
51.00	05100	RECOVERY ROOM	23,491	2,507,974	0.009367	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	142,873	1,371,631	0.104163	0	52.00
53.00	05300	ANESTHESIOLOGY	16,919	3,571,698	0.004737	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,338	12,674,536	0.016201	68,342	1,107 54.00
56.00	05600	RADIOISOTOPE	42,977	3,151,651	0.013636	0	56.00
57.00	05700	CT SCAN	100,715	19,315,834	0.005214	80,293	419 57.00
58.00	05800	MRI	47,910	4,484,875	0.010683	11,290	121 58.00
59.00	05900	CARDIAC CATHETERIZATION	91,440	7,928,439	0.011533	0	59.00
60.00	06000	LABORATORY	169,952	31,657,714	0.005368	811,763	4,358 60.00
65.00	06500	RESPIRATORY THERAPY	25,641	6,276,927	0.004085	318,910	1,303 65.00
66.00	06600	PHYSICAL THERAPY	68,874	3,397,466	0.020272	26,332	534 66.00
67.00	06700	OCCUPATIONAL THERAPY	3,191	329,897	0.009673	9,227	89 67.00
68.00	06800	SPEECH PATHOLOGY	1,952	152,297	0.012817	7,302	94 68.00
69.00	06900	ELECTROCARDIOLOGY	82,313	7,891,453	0.010431	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,914	173,075	0.057282	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,190	6,936,392	0.007957	6,249	50 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,519	8,159,277	0.010726	985	11 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,656	21,286,128	0.003554	1,031,263	3,665 73.00
74.00	07400	RENAL DIALYSIS	661	652,550	0.001013	71,300	72 74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0 76.00
76.01	03060	WOUND CARE	2,240	419,259	0.005343	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	140,193	2,050,485	0.068371	0	90.00
91.00	09100	EMERGENCY	700,219	33,393,820	0.020969	111,499	2,338 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,014,728	0.000000	0	0 92.00
200.00		Total (lines 50-199)	2,485,330	196,012,588		2,554,755	14,161 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
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
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
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 140292 Component CCN: 14S292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	14,214,482	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	2,507,974	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,371,631	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	3,571,698	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	12,674,536	0.000000	0.000000	68,342	54.00
56.00	05600 RADIOISOTOPE	0	3,151,651	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	19,315,834	0.000000	0.000000	80,293	57.00
58.00	05800 MRI	0	4,484,875	0.000000	0.000000	11,290	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	7,928,439	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	31,657,714	0.000000	0.000000	811,763	60.00
65.00	06500 RESPIRATORY THERAPY	0	6,276,927	0.000000	0.000000	318,910	65.00
66.00	06600 PHYSICAL THERAPY	0	3,397,466	0.000000	0.000000	26,332	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	329,897	0.000000	0.000000	9,227	67.00
68.00	06800 SPEECH PATHOLOGY	0	152,297	0.000000	0.000000	7,302	68.00
69.00	06900 ELECTROCARDIOLOGY	0	7,891,453	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	173,075	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,936,392	0.000000	0.000000	6,249	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,159,277	0.000000	0.000000	985	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,286,128	0.000000	0.000000	1,031,263	73.00
74.00	07400 RENAL DIALYSIS	0	652,550	0.000000	0.000000	71,300	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03060 WOUND CARE	0	419,259	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	2,050,485	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	33,393,820	0.000000	0.000000	111,499	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,014,728	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	196,012,588			2,554,755	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
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	1,183	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	4,020	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
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	1,995	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	69	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	141	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,783	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01 03060 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	10,191	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
	Title XVII	Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
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
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
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 11:56 am
		Component CCN: 14S292	Title XVIII	Subprovider - IPF
				PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.247597	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.180780	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.190157	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.054402	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163991	1,183	0	0	194 54.00
56.00	05600	RADIOISOTOPE	0.125641	0	0	0	0 56.00
57.00	05700	CT SCAN	0.053350	4,020	0	0	214 57.00
58.00	05800	MRI	0.090078	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.166459	0	0	0	0 59.00
60.00	06000	LABORATORY	0.116677	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.188484	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.351023	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315877	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.115931	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.103577	1,995	0	0	207 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.404697	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.228383	69	0	0	16 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.416210	141	0	0	59 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227442	2,783	105	86	633 73.00
74.00	07400	RENAL DIALYSIS	0.314004	0	0	0	0 74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0 76.00
76.01	03060	WOUND CARE	1.080614	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.392872	0	0	0	0 90.00
91.00	09100	EMERGENCY	0.153119	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.450469	0	0	0	0 92.00
200.00		Subtotal (see instructions)		10,191	105	86	1,323 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00		Net Charges (line 200 +/- line 201)		10,191	105	86	1,323 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140292	Period: From 01/01/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 11:56 am
	Component CCN: 14S292	To 12/31/2014	
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
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
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
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
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	24	20	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01 03060 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	24	20	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	24	20	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/27/2015 11:56 am	
		Component CCN: 14S292		Title XIX		Subprovider - IPF Tefra	
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	390,152	14,214,482	0.027448	0	50.00
51.00	05100	RECOVERY ROOM	23,491	2,507,974	0.009367	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	142,873	1,371,631	0.104163	0	52.00
53.00	05300	ANESTHESIOLOGY	16,919	3,571,698	0.004737	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205,338	12,674,536	0.016201	0	54.00
56.00	05600	RADIOISOTOPE	42,977	3,151,651	0.013636	0	56.00
57.00	05700	CT SCAN	100,715	19,315,834	0.005214	0	57.00
58.00	05800	MRI	47,910	4,484,875	0.010683	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	91,440	7,928,439	0.011533	0	59.00
60.00	06000	LABORATORY	169,952	31,657,714	0.005368	0	60.00
65.00	06500	RESPIRATORY THERAPY	25,641	6,276,927	0.004085	0	65.00
66.00	06600	PHYSICAL THERAPY	68,874	3,397,466	0.020272	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,191	329,897	0.009673	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,952	152,297	0.012817	0	68.00
69.00	06900	ELECTROCARDIOLOGY	82,313	7,891,453	0.010431	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,914	173,075	0.057282	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,190	6,936,392	0.007957	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,519	8,159,277	0.010726	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,656	21,286,128	0.003554	0	73.00
74.00	07400	RENAL DIALYSIS	661	652,550	0.001013	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	76.00
76.01	03060	WOUND CARE	2,240	419,259	0.005343	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	140,193	2,050,485	0.068371	0	90.00
91.00	09100	EMERGENCY	700,219	33,393,820	0.020969	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,014,728	0.000000	0	92.00
200.00		Total (lines 50-199)	2,485,330	196,012,588		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
	Title XIX	Subprovider - IPF	Tefra

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
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
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
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 140292 Component CCN: 14S292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	14,214,482	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	2,507,974	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,371,631	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	3,571,698	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	12,674,536	0.000000	0.000000	0	54.00
56.00	05600 RADIOISOTOPE	0	3,151,651	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	19,315,834	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	4,484,875	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	7,928,439	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	31,657,714	0.000000	0.000000	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	6,276,927	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	3,397,466	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	329,897	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	152,297	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	7,891,453	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	173,075	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,936,392	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,159,277	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21,286,128	0.000000	0.000000	0	73.00
74.00	07400 RENAL DIALYSIS	0	652,550	0.000000	0.000000	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03060 WOUND CARE	0	419,259	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	2,050,485	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	33,393,820	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4,014,728	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	196,012,588			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140292 Component CCN: 14S292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
Title XIX		Subprovider - IPF	Tefra

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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
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
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
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 140292 Component CCN: 14S292	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:56 am
	Title XIX	Subprovider - IPF	Tefra

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
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
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
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/27/2015 11:56 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)		23,013	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,013	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)		20,871	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)		7,983	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)		19,430,189	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)		19,430,189	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)		19,430,189	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)		844.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,740,127	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)		6,740,127	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 11:56 am	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,668,626	2,194	1,672.12	1,140	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)				5,756,939	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				14,403,283	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)				675,380	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				314,416	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				989,796	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				13,413,487	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				2,142	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				844.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,808,512	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/27/2015 11:56 am	
Title XVIII		Hospital		PPS			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,642,783	19,430,189	0.084548	1,808,512	152,906	90.00
91.00	Nursing School cost	0	19,430,189	0.000000	1,808,512	0	91.00
92.00	Allied health cost	0	19,430,189	0.000000	1,808,512	0	92.00
93.00	All other Medical Education	0	19,430,189	0.000000	1,808,512	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 14S292		Date/Time Prepared: 5/27/2015 11:56 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,976	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,976	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)		4,976	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,809	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)		4,128,222	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)		4,128,222	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)		4,128,222	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)		829.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,160,061	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,160,061	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 14S292		Date/Time Prepared: 5/27/2015 11:56 am			
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					460,187		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,620,248		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)					193,040		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,161		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					207,201		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,413,047		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292 Component CCN: 14S292		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/27/2015 11:56 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	252,184	4,128,222	0.061088	0	0	90.00
91.00	Nursing School cost	0	4,128,222	0.000000	0	0	91.00
92.00	Allied health cost	0	4,128,222	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,128,222	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/27/2015 11:56 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		23,013	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,013	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)		20,871	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)		4,714	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)		910	15.00
16.00	Nursery days (title V or XIX only)		759	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)		19,430,189	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)		19,430,189	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)		19,430,189	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)		844.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,980,077	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,980,077	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
Title XIX		Hospital		Cost			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1,173,599	910	1,289.67	759	978,860		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,668,626	2,194	1,672.12	171	285,933		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							
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)					5,244,870		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						2,142	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						844.31	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,808,512	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/27/2015 11:56 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,642,783	19,430,189	0.084548	1,808,512	152,906	90.00
91.00	Nursing School cost	0	19,430,189	0.000000	1,808,512	0	91.00
92.00	Allied health cost	0	19,430,189	0.000000	1,808,512	0	92.00
93.00	All other Medical Education	0	19,430,189	0.000000	1,808,512	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Component CCN: 14S292		Date/Time Prepared: 5/27/2015 11:56 am
		Title XIX	Subprovider - IPF	Tefra
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,976	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,976	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)		4,976	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)		188	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)		910	15.00
16.00	Nursery days (title V or XIX only)		759	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)		4,128,222	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)		4,128,222	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)		4,128,222	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)		829.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		155,970	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)		155,970	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 14S292				Date/Time Prepared: 5/27/2015 11:56 am	
		Title XIX		Subprovider - IPF		Tefra	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					155,970	0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					155,970	0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					10	0	54.00
55.00 Target amount per discharge					0.00	0	55.00
56.00 Target amount (line 54 x line 55)					0	0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					-155,970	0	57.00
58.00 Bonus payment (see instructions)					0	0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	0	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	0	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	0	61.00
62.00 Relief payment (see instructions)					0	0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	0	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140292 Component CCN: 14S292		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/27/2015 11:56 am	
		Title XIX		Subprovider - IPF		Tefra	
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	0	4,128,222	0.000000	0	0	90.00
91.00	Nursing School cost	0	4,128,222	0.000000	0	0	91.00
92.00	Allied health cost	0	4,128,222	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,128,222	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/27/2015 11:56 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		10,634,404	30.00
31.00	03100	INTENSIVE CARE UNIT		2,702,645	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.247597	2,165,764	50.00
51.00	05100	RECOVERY ROOM	0.180780	212,257	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.190157	7,294	52.00
53.00	05300	ANESTHESIOLOGY	0.054402	357,316	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163991	1,558,326	54.00
56.00	05600	RADIOISOTOPE	0.125641	482,401	56.00
57.00	05700	CT SCAN	0.053350	2,343,609	57.00
58.00	05800	MRI	0.090078	343,806	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.166459	1,153,010	59.00
60.00	06000	LABORATORY	0.116677	7,266,955	60.00
65.00	06500	RESPIRATORY THERAPY	0.188484	2,630,492	65.00
66.00	06600	PHYSICAL THERAPY	0.351023	313,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.315877	139,922	67.00
68.00	06800	SPEECH PATHOLOGY	0.115931	93,309	68.00
69.00	06900	ELECTROCARDIOLOGY	0.103577	1,721,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.404697	59,592	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.228383	1,203,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.416210	1,174,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227442	5,910,828	73.00
74.00	07400	RENAL DIALYSIS	0.314004	389,727	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	76.00
76.01	03060	WOUND CARE	1.080614	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.392872	0	90.00
91.00	09100	EMERGENCY	0.153119	2,437,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.450469	388,350	92.00
200.00		Total (sum of lines 50-94 and 96-98)		32,354,059	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		32,354,059	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3	
		Component CCN: 14S292		Date/Time Prepared: 5/27/2015 11:56 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		5,811,532		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.247597	0	0	50.00
51.00	05100 RECOVERY ROOM	0.180780	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.190157	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.054402	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.163991	68,342	11,207	54.00
56.00	05600 RADIOISOTOPE	0.125641	0	0	56.00
57.00	05700 CT SCAN	0.053350	80,293	4,284	57.00
58.00	05800 MRI	0.090078	11,290	1,017	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.166459	0	0	59.00
60.00	06000 LABORATORY	0.116677	811,763	94,714	60.00
65.00	06500 RESPIRATORY THERAPY	0.188484	318,910	60,109	65.00
66.00	06600 PHYSICAL THERAPY	0.351023	26,332	9,243	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.315877	9,227	2,915	67.00
68.00	06800 SPEECH PATHOLOGY	0.115931	7,302	847	68.00
69.00	06900 ELECTROCARDIOLOGY	0.103577	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.404697	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228383	6,249	1,427	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416210	985	410	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.227442	1,031,263	234,553	73.00
74.00	07400 RENAL DIALYSIS	0.314004	71,300	22,388	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	76.00
76.01	03060 WOUND CARE	1.080614	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.392872	0	0	90.00
91.00	09100 EMERGENCY	0.153119	111,499	17,073	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.450469	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,554,755	460,187	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		2,554,755		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/27/2015 11:56 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.247597	0	0	50.00
51.00	05100 RECOVERY ROOM	0.180780	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.190157	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.054402	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.163991	0	0	54.00
56.00	05600 RADIOISOTOPE	0.125641	0	0	56.00
57.00	05700 CT SCAN	0.053350	0	0	57.00
58.00	05800 MRI	0.090078	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.166459	0	0	59.00
60.00	06000 LABORATORY	0.116677	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.188484	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.351023	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.315877	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.115931	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.103577	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.404697	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228383	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416210	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.227442	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.314004	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	76.00
76.01	03060 WOUND CARE	1.080614	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.392872	0	0	90.00
91.00	09100 EMERGENCY	0.153119	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.450469	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3
		Component CCN: 14S292	Date/Time Prepared: 5/27/2015 11:56 am	
		Title XIX	Subprovider - IPF	Tefra
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.247597	0	50.00
51.00	05100 RECOVERY ROOM	0.180780	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.190157	0	52.00
53.00	05300 ANESTHESIOLOGY	0.054402	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.163991	0	54.00
56.00	05600 RADIOISOTOPE	0.125641	0	56.00
57.00	05700 CT SCAN	0.053350	0	57.00
58.00	05800 MRI	0.090078	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.166459	0	59.00
60.00	06000 LABORATORY	0.116677	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.188484	0	65.00
66.00	06600 PHYSICAL THERAPY	0.351023	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.315877	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.115931	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.103577	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.404697	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.228383	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.416210	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.227442	0	73.00
74.00	07400 RENAL DIALYSIS	0.314004	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	76.00
76.01	03060 WOUND CARE	1.080614	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.392872	0	90.00
91.00	09100 EMERGENCY	0.153119	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.450469	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/27/2015 11:56 am
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		8,140,292	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,348,910	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)		233,269	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		962,591	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		110.96	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (F)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		8.90	30.00
31.00	Percentage of Medicaid patient days (see instructions)		38.87	31.00
32.00	Sum of lines 30 and 31		47.77	32.00
33.00	Allowable disproportionate share percentage (see instructions)		28.63	33.00
34.00	Disproportionate share adjustment (see instructions)		750,765	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/27/2015 11:56 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000300661	0.000292178	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,719,893	2,234,473	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,034,330	563,210	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,597,540		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		14,070,776		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)		14,070,776		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		943,817		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)		15,014,593		59.00
60.00	Primary payer payments		7,439		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		15,007,154		61.00
62.00	Deductibles billed to program beneficiaries		1,003,776		62.00
63.00	Coinurance billed to program beneficiaries		186,656		63.00
64.00	Allowable bad debts (see instructions)		553,526		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		359,792		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		434,369		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,176,514		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)		-9,662		70.93
70.94	HRR adjustment amount (see instructions)		-12,337		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/27/2015 11:56 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,154,515		71.00
71.01	Sequestration adjustment (see instructions)		283,090		71.01
72.00	Interim payments		13,538,367		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)		333,058		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		586,304		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 5/27/2015 11:56 am	
		PPS					
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	8.90	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	38.87	0.00			38.87	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	47.77	0.00			38.87	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	110.96	0.00			110.96	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	28.63	0.00			21.28	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	8.90	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	5,702	0			5,702	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1,214	0			1,214	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	31	0			31	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,404	0			2,404	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	9,351	0			9,351	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	23,975	0			23,975	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	82	0			82	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	24,057	0			24,057	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	38.87	0.00			38.87	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140292		Period: From 01/01/2014 To 12/31/2014		Worksheet DSH Date/Time Prepared: 5/27/2015 11:56 am	
		Title XVII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	28.63		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		28.63		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		28.63		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet DSH Date/Time Prepared: 5/27/2015 11:56 am
		Title XVIII	Hospital	PPS

		Revised Percentage 6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	21.28	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	21.28	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	21.28	31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140292

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2015 11:56 am

		Title XVIII		Hospital		PPS		
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,140,292	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,348,910	0	0	10,489,203	10,489,203	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	233,269	0	0	233,269	233,269	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	962,591	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2863	0.2863	0.2863	0.2863		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	750,765	0	0	750,765	750,765	11.00
11.01	Uncompensated care payments	36.00	2,597,540	0	2,034,330	563,210	2,597,540	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,070,776	0	2,034,330	12,036,446	14,070,776	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,070,776	0	2,034,330	12,036,446	14,070,776	15.00
16.00	Payment for inpatient program capital	50.00	943,817	0	0	943,817	943,817	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140292

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/27/2015 11:56 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	2,034,330	12,980,263	15,014,593	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	838,330	0	0	838,330	838,330	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	20,397	0	0	20,397	20,397	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1015	0.1015	0.1015	0.1015		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	85,090	0	0	85,090	85,090	25.00
26.00	Total prospective capital payments (see instructions)	12.00	943,817	0	0	943,817	943,817	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/27/2015 11:56 am
		Title XVIII	Hospital	PPS

	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00				1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,140,292	8,140,292		1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,348,910		2,348,910	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00	233,269	0	233,269	2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	2.01	
3.00	Operating outlier reconciliation	2.01	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	962,591	962,591	0	4.00	
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	9.01	
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2863	0.2863	0.2863	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	750,765	582,642	168,123	11.00	
11.01	Uncompensated care payments	36.00	2,597,540	2,034,330	563,210	11.01	
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	14,070,776	10,757,264	3,313,512	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,070,776	10,757,264	3,313,512	15.00	
16.00	Payment for inpatient program capital	50.00	943,817	0	943,817	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	17.00	
17.01	Net organ acquisition cost	55.00	0	0	0	17.01	
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	18.00	
19.00	SUBTOTAL			10,757,264	4,257,329	15,014,593	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 140292

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/27/2015 11:56 am

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	838,330	0	838,330	838,330	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	20,397	0	20,397	20,397	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1015	0.1015	0.1015		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	85,090	0	85,090	85,090	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	943,817	0	943,817	943,817	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	-9,662	0	-9,662	-9,662	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-12,337	0	-12,337	-12,337	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0		0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 11:56 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,875	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,119,618	2.00
3.00	PPS payments		3,712,342	3.00
4.00	Outlier payment (see instructions)		17,641	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)		6,875	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		30,227	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)		30,227	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)		30,227	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		23,352	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)		6,875	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)		3,729,983	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		25	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		782,917	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,953,916	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,953,916	30.00
31.00	Primary payer payments		1,231	31.00
32.00	Subtotal (line 30 minus line 31)		2,952,685	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)		256,187	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		166,522	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		228,123	36.00
37.00	Subtotal (see instructions)		3,119,207	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,119,207	40.00
40.01	Sequestration adjustment (see instructions)		62,384	40.01
41.00	Interim payments		3,039,749	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		17,074	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
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 11:56 am
		Component CCN: 14S292	Title XVII	Subprovider - IPF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		44	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,323	2.00
3.00	PPS payments		654	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		44	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		191	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)		191	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)		191	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		147	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)		44	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)		654	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)		173	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)		525	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)		525	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		525	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		525	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		525	40.00
40.01	Sequestration adjustment (see instructions)		11	40.01
41.00	Interim payments		556	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-42	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
		Overrides		
		1.00		
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140292

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2015 11:56 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		13,384,169		3,045,391	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	10/27/2014	154,198		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	10/27/2014	5,642	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)		154,198		-5,642	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)		13,538,367		3,039,749	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		333,058		17,074	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		13,871,425		3,056,823	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140292
Component CCN: 14S292

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2015 11:56 am
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3,134,620		556	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,134,620		556	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		30,024		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		42	6.02
7.00	Total Medicare program liability (see instructions)		3,164,644		514	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: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/27/2015 11:56 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		4,859	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		9,123	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		599	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		23,065	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		239,458,291	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		9,808,878	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)		301,277	8.00
9.00	Sequestration adjustment amount (see instructions)		6,026	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		295,251	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		309,903	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)		-14,652	32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/27/2015 11:56 am
		Component CCN: 14S292	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		3,403,881	1.00
2.00	Net IPF PPS Outlier Payments		10,617	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		13.632877	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		3,414,498	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		3,414,498	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		3,414,498	18.00
19.00	Deductibles		149,344	19.00
20.00	Subtotal (line 18 minus line 19)		3,265,154	20.00
21.00	Coinsurance		66,560	21.00
22.00	Subtotal (line 20 minus line 21)		3,198,594	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		47,130	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		30,635	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		37,828	25.00
26.00	Subtotal (sum of lines 22 and 24)		3,229,229	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		3,229,229	31.00
31.01	Sequestration adjustment (see instructions)		64,585	31.01
32.00	Interim payments		3,134,620	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		30,024	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		10,617	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 140292

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

Worksheet G

Date/Time Prepared:
5/27/2015 11:56 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	-13,048	0	0	0	1.00
2.00	Temporary investments	3,870	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,540,724	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,630,382	0	0	0	6.00
7.00	Inventory	1,807,664	0	0	0	7.00
8.00	Prepaid expenses	776,521	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,485,349	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,869,112	0	0	0	12.00
13.00	Land improvements	78,294	0	0	0	13.00
14.00	Accumulated depreciation	-76,891	0	0	0	14.00
15.00	Buildings	26,822,409	0	0	0	15.00
16.00	Accumulated depreciation	-12,791,076	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,355,288	0	0	0	19.00
20.00	Accumulated depreciation	-6,746,821	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	14,102,660	0	0	0	23.00
24.00	Accumulated depreciation	-9,213,476	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	21,399,499	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,419,733	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	8,539,543	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,959,276	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,844,124	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,478,626	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,295,894	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	842,847	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,809,246	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,426,613	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,933,481	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	19,244	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,952,725	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,379,338	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	23,464,786				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)	23,464,786	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,844,124	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140292

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

Worksheet G-1

Date/Time Prepared:
5/27/2015 11:56 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		29,731,462		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-6,292,473			2.00
3.00	Total (sum of line 1 and line 2)		23,438,989		0	3.00
4.00	GENERAL FUND	408,146		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)		408,146		0	10.00
11.00	Subtotal (line 3 plus line 10)		23,847,135		0	11.00
12.00	DONOR RESTRICTED	381,940		0		12.00
13.00	ROUNDING	409		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)		382,349		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,464,786		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	GENERAL FUND		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	DONOR RESTRICTED		0			12.00
13.00	ROUNDING		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: 140292

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2015 11:56 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	29,907,590		29,907,590	1.00
2.00	SUBPROVIDER - IPF	7,563,520		7,563,520	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	37,471,110		37,471,110	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,280,912		5,280,912	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)	5,280,912		5,280,912	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,752,022		42,752,022	17.00
18.00	Ancillary services	76,104,991	87,207,910	163,312,901	18.00
19.00	Outpatient services	7,252,545	26,141,275	33,393,820	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OP PHARMACY	0	571,330	571,330	27.00
27.01	PHYSICIAN CHARGES	0	463,276	463,276	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	126,109,558	114,383,791	240,493,349	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		88,889,794		29.00
30.00	BAD DEBT	3,251,083			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		3,251,083		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)		92,140,877		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140292

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

Worksheet G-3

Date/Time Prepared:
5/27/2015 11:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	240,493,349	1.00
2.00	Less contractual allowances and discounts on patients' accounts	162,845,035	2.00
3.00	Net patient revenues (line 1 minus line 2)	77,648,314	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	92,140,877	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-14,492,563	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	EHR, OTHER OPERATING, NON OPERATING	8,200,090	24.00
25.00	Total other income (sum of lines 6-24)	8,200,090	25.00
26.00	Total (line 5 plus line 25)	-6,292,473	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)	-6,292,473	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140292	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/27/2015 11:56 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		838,330	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		20,397	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)		63.42	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)		8.90	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		38.87	8.00
9.00	Sum of lines 7 and 8		47.77	9.00
10.00	Allowable disproportionate share percentage (see instructions)		10.15	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		85,090	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		943,817	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