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In Lieu of Form CMS-2552-10

Health Financial Systems CENTERPOINTE HOSPITAL

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).

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 264012

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

FORM APPROVED OMB NO. 0938-0050

Worksheet 5 Parts I-III Date/Time Prepared: 5/27/2015 11:33 am

PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report

2. Manually submitted cost report

3. If this is an amended report enter the number of times the provider resubmitted this cost report

4. Medicare Utilization. Enter "F" for full or "L" for low.

Date: _____ Time: _____

Contractor use only

5. 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. Initial Report for this Provider CCN

9. Final Report for this Provider CCN

10. NPR Date: _____

11. Contractor's Vendor Code: _____

12. 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 CENTERPOINTE HOSPITAL (264012) 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) *J. Maest*
 Officer or Administrator of Provider(s)

CPo
 Title

05/29/2015
 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	109,595	370,720		0	30,001
2.00 Subprovider - IPF	0	0	0		0	0
3.00 Subprovider - IRF	0	0	0		0	0
5.00 Swing bed - SNF	0	0	0		0	0
6.00 Swing bed - NF	0	0	0		0	0
12.00 CMHC I	0	0	0		0	0
200.00 Total	0	109,595	370,720		0	30,001

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.

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: 264012
 Period: From 01/01/2014 To 12/31/2014
 worksheet 5
 Parts I-III
 Date/Time Prepared: 5/29/2015 9:49 am

PART I - COST REPORT STATUS Date: 5/29/2015 Time: 9:49 am

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

 Title

 Date

	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	109,595	370,720	0	30,001	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	109,595	370,720	0	30,001	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: 264012	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:33 am
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	1.00	2.00	3.00	4.00	
Hospital and Hospital Health Care Complex Address:					
1.00	Street: 4801 WELDON SPRINGS PARKWAY		PO BOX:		1.00
2.00	City: ST CHARLES		State: MO Zip Code: 63304 County: ST. CHARLES		2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
	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	CENTERPOINTE HOSPITAL	264012	41180	4	12/31/1980	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.01	Hospital-Based (CMHC) II									17.01
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)	4		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N							22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N							22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N							22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N							22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
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 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.	0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 264012	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:33 am
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		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.	0				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.					37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete wkst. L, Pt. III and wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					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.					58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 264012

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

Worksheet S-2
Part I
Date/Time Prepared:
5/27/2015 11:33 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 264012	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:33 am		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0.00	0.00	0.000000		67.00
				1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y				70.00
71.00	If line 70 yes: column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(C)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	N	N	0		71.00
75.00	Inpatient Rehabilitation Facility PPS 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		
80.00	Long Term Care Hospital PPS 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
85.00	TEFRA Providers 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 264012

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

Worksheet S-2
Part I
Date/Time Prepared:
5/27/2015 11:33 am

		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	Occupational	Speech
		1.00	2.00	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
				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
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	38,452	0	0
				1.00
				2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 264012	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:33 am
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		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)		N				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:	Contractor's Name:		Contractor's Number:			141.00
142.00	Street:	PO Box:					142.00
143.00	City:	State:		Zip Code:			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.			N	145.00		
				1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
161.01	INTEREST EXPENSES		N	N	N		161.01
					1.00		
Multicampus							
165.00	Is this hospital part of a Multicampus 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.				N		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)						0.00
							169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 264012	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:33 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)			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)			171.00
			N	

LOW/NO UTILIZATION MEDICARE COST REPORT

Provider CCN: 264012

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

worksheet Low/No
Date/Time Prepared:
5/29/2015 11:08 am

		Data	Source	
		1.00	2.00	
50.00	Street	4801 WELDON SPRINGS PARKWAY	S-2 Line 1.00, Col 1.00	50.00
51.00	PO Box		S-2 Line 1.00, Col 2.00	51.00
52.00	City	ST CHARLES	S-2 Line 2.00, Col 1.00	52.00
53.00	State		MO S-2 Line 2.00, Col 2.00	53.00
54.00	Zip Code	63304	S-2 Line 2.00, Col 3.00	54.00
55.00	Component Name	CENTERPOINTE HOSPITAL	S-2 Line 3.00, Col 1.00	55.00
56.00	CCN Number	264012	S-2 Line 3.00, Col 2.00	56.00
57.00	Provider Type		4 S-2 Line 3.00, Col 4.00	57.00
58.00	Date Certified	12/31/1980	S-2 Line 3.00, Col 5.00	58.00
59.00	Type of Control		4 S-2 Line 21.00, Col 1.00	59.00
60.00	Fiscal Year Begin	01/01/2014	S-2 Line 20.00, Col 1.00	60.00
61.00	Fiscal Year End	12/31/2014	S-2 Line 20.00, Col 2.00	61.00

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
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

	Description	Part A		Part B		
		Y/N	Date	Y/N		
	0	1.00	2.00	3.00		
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 relifed 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?					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.					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.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					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.	RONALD		MOORE		41.00
42.00	Enter the employer/company name of the cost report preparer.	CENTERPOINTE HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	636-441-7300		RMOORE@CPHMO.NET		43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MEDICARE SPECIALIST	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: 264012

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

Worksheet S-2
Part V
Date/Time Prepared:
5/27/2015 11:33 am

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	RONALD	1.00
2.00	Last Name	MOORE	2.00
3.00	Title	MEDICARE SPECIALIST	3.00
4.00	Employer	CENTERPOINTE HOSPITAL	4.00
5.00	Phone Number	(636)441-7300	5.00
6.00	E-mail Address	RMOORE@CPHMO.NET	6.00
7.00	Department	BUSINESS OFFICE	7.00
8.00	Mailing Address 1	4801 WELDON SPRING PARKWAY	8.00
9.00	Mailing Address 2		9.00
10.00	City	ST CHARLES	10.00
11.00	State	MO	11.00
12.00	Zip	63304	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	TARIQ	13.00
14.00	Last Name	MALIK	14.00
15.00	Title	CHIEF FINANCIAL OFFICER	15.00
16.00	Employer	CENTERPOINTE HOSPITAL	16.00
17.00	Phone Number	(636)441-7300	17.00
18.00	E-mail Address	TFMALIK@USA.NET	18.00
19.00	Department	BUSINESS OFFICE	19.00
20.00	Mailing Address 1	4801 WELDON SPRING PARKWAY	20.00
21.00	Mailing Address 2		21.00
22.00	City	ST CHARLES	22.00
23.00	State	MO	23.00
24.00	Zip	63304	24.00

Provider CCN: 264012

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

Worksheet S-2
Part IX
Date/Time Prepared:
5/27/2015 11:33 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: 264012

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2015 11:33 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V	
	Line Number				Visits / Trips		
	1.00	2.00	3.00	4.00	5.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	104	37,960	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)		104	37,960	0.00	0		7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0		8.00
8.01 OTHER SPECIAL CARE (SPECIFY)	31.01	0	0	0.00	0		8.01
8.02 CHEMICAL DEPENDENCY/SAFE	31.02	46	16,790	0.00	0		8.02
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)		150	54,750	0.00	0		14.00
15.00 CAH visits					0		15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)	30.00				0		24.10
25.00 CMHC - CMHC	99.00				0		25.00
25.01 CMHC - INTEREST EXPENSES	99.01				0		25.01
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)		150			0		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)		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

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)	7,343	4,362	29,882			1.00
2.00 HMO and other (see instructions)	945	1,518				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)	7,343	4,362	29,882			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
8.01 OTHER SPECIAL CARE (SPECIFY)	0	0	0			8.01
8.02 CHEMICAL DEPENDENCY/SAFE	0	0	7,170			8.02
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)	7,343	4,362	37,052	0.00	370.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.01 CMHC - INTEREST EXPENSES	0	0	0	0.00	0.00	25.01
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	370.00	27.00
28.00 Observation Bed Days		0	0			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	0	0			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: 264012

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2015 11:33 am

Component	Full Time Equivalents	Discharges				Total All Patients	
		Nonpaid workers	Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	595	476	4,307	1.00
2.00 HMO and other (see instructions)				137	324		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
8.01 OTHER SPECIAL CARE (SPECIFY)							8.01
8.02 CHEMICAL DEPENDENCY/SAFE							8.02
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	595	476		4,307	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC	0.00						25.00
25.01 CMHC - INTEREST EXPENSES	0.00						25.01
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 264012

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

Worksheet A

Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		140,627	140,627	2,401,190	2,541,817	1.00
2.00	00200		552,657	552,657	507,495	1,060,152	2.00
2.01	00201		330,402	330,402	-330,402	0	2.01
4.00	00400	156,203	5,235,950	5,392,153	-4,029	5,388,124	4.00
5.00	00500	5,246,838	9,214,941	14,461,779	-1,477,692	12,984,087	5.00
6.00	00600	238,737	631,998	870,735	-15,954	854,781	6.00
8.00	00800	0	109,687	109,687	0	109,687	8.00
9.00	00900	0	382,707	382,707	0	382,707	9.00
10.00	01000	330,633	944,780	1,275,413	-22	1,275,391	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	811,952	28,227	840,179	-4,048	836,131	13.00
15.00	01500	237,797	806,194	1,043,991	-424	1,043,567	15.00
16.00	01600	437,435	209,476	646,911	-19,623	627,288	16.00
17.00	01700	537,406	9,299	546,705	-190	546,515	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,935,724	1,058,169	7,993,893	203,929	8,197,822	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	02400	0	0	0	0	0	31.01
31.02	03101	1,383,523	260,586	1,644,109	22,725	1,666,834	31.02
ANCILLARY SERVICE COST CENTERS							
70.00	07000	131,572	181,134	312,706	-62	312,644	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,944,536	3,269,800	7,214,336	-4,356,734	2,857,602	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.01	09901	0	119,240	119,240	-119,240	0	99.01
SPECIAL PURPOSE COST CENTERS							
118.00		20,392,356	23,485,874	43,878,230	-3,193,081	40,685,149	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
191.01	19101	0	0	0	123,231	123,231	191.01
191.02	19102	432,326	3,313,753	3,746,079	-1,544	3,744,535	191.02
191.03	19103	0	0	0	3,071,394	3,071,394	191.03
200.00		20,824,682	26,799,627	47,624,309	0	47,624,309	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 264012

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

Worksheet A

Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	0	2,541,817	1.00
2.00	00200	0	1,060,152	2.00
2.01	00201	0	0	2.01
4.00	00400	0	5,388,124	4.00
5.00	00500	-4,852,822	8,131,265	5.00
6.00	00600	0	854,781	6.00
8.00	00800	0	109,687	8.00
9.00	00900	0	382,707	9.00
10.00	01000	-83,020	1,192,371	10.00
11.00	01100	0	0	11.00
13.00	01300	0	836,131	13.00
15.00	01500	0	1,043,567	15.00
16.00	01600	-4,244	623,044	16.00
17.00	01700	0	546,515	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	-274,386	7,923,436	30.00
31.00	03100	0	0	31.00
31.01	02400	0	0	31.01
31.02	03101	-104,800	1,562,034	31.02
ANCILLARY SERVICE COST CENTERS				
70.00	07000	0	312,644	70.00
73.00	07300	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	-359,776	2,497,826	90.00
OTHER REIMBURSABLE COST CENTERS				
99.00	09900	0	0	99.00
99.01	09901	0	0	99.01
SPECIAL PURPOSE COST CENTERS				
118.00		-5,679,048	35,006,101	118.00
NONREIMBURSABLE COST CENTERS				
191.00	19100	0	0	191.00
191.01	19101	0	123,231	191.01
191.02	19102	0	3,744,535	191.02
191.03	19103	0	3,071,394	191.03
200.00		-5,679,048	41,945,261	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 264012

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

Worksheet Non-CMS W
Date/Time Prepared:
5/27/2015 11:33 am

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
2.01 CAP REL COSTS - OTHER	00201		2.01
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
6.00 MAINTENANCE & REPAIRS	00600		6.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
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
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
31.01 OTHER SPECIAL CARE (SPECIFY)	02400		31.01
31.02 CHEMICAL DEPENDENCY/SAFE	03101		31.02
ANCILLARY SERVICE COST CENTERS			
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	09000		90.00
OTHER REIMBURSABLE COST CENTERS			
99.00 CMHC	09900		99.00
99.01 INTEREST EXPENSES	09901		99.01
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
191.00 RESEARCH	19100		191.00
191.01 COMMUNITY RELATION	19101		191.01
191.02 RETAIL PHARMACY	19102		191.02
191.03 NON HOSPITAL OP	19103		191.03
200.00 TOTAL (SUM OF LINES 118-199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
B - DEFAULT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43,040	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
TOTALS			0	43,040	
C - DEFAULT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,271,214	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	58,480	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
TOTALS			0	2,329,694	
D - TO RECLASS LABORATORY					
1.00	CHEMICAL DEPENDENCY/SAFE	31.02	0	16,535	1.00
TOTALS			0	16,535	
E - TO RECLASS COMMUNITY RELATION EXP					
1.00	COMMUNITY RELATION	191.01	61,179	62,052	1.00
TOTALS			61,179	62,052	
F - TO RECLASS PROPERTY TAX					
1.00		0.00	0	0	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	78,777	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	251,625	3.00
TOTALS			0	330,402	
G - TO RECLASS LIGHT DUTY					
1.00		0.00	0	0	1.00
3.00	ADULTS & PEDIATRICS	30.00	15,187	0	3.00
TOTALS			15,187	0	
H - TO RECLASS ORIENTATION EXP					
1.00		0.00	0	0	1.00
3.00	ADULTS & PEDIATRICS	30.00	212,402	0	3.00
TOTALS			212,402	0	
I - TO RECLASS INTEREST EXP					
1.00		0.00	0	0	1.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	119,240	3.00
TOTALS			0	119,240	
J - TO RECLASS INSURANCE EXP					
1.00		0.00	0	0	1.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,199	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	197,390	4.00
TOTALS			0	248,589	
K - TO RECLASS TRANSPORTATION COST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	679,843	1.00
TOTALS			0	679,843	
L - TO RECLASS RADIOLOGY COST					
1.00	CHEMICAL DEPENDENCY/SAFE	31.02	0	6,268	1.00
TOTALS			0	6,268	
M - TO RECLASS NON HOSPITAL OP COST					
1.00	NON HOSPITAL OP	191.03	1,836,982	1,223,759	1.00
2.00	NON HOSPITAL OP	191.03	5,124	5,529	2.00
TOTALS			1,842,106	1,229,288	
500.00	Grand Total: Increases		2,130,874	5,064,951	500.00

		Decreases			Wkst. A-7 Ref.		
Cost Center		Line #	Salary	Other			
6.00		7.00	8.00	9.00	10.00		
B - DEFAULT							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	428	0		1.00
2.00	DIETARY	10.00	0	22	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	47	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	268	0		4.00
5.00	SOCIAL SERVICE	17.00	0	190	0		5.00
6.00	CHEMICAL DEPENDENCY/SAFE	31.02	0	13	0		6.00
7.00	PHARMACY	15.00	0	424	0		7.00
8.00	CLINIC	90.00	0	40,168	0		8.00
9.00	RETAIL PHARMACY	191.02	0	1,480	0		9.00
	TOTALS		0	43,040			
C - DEFAULT							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,601	14		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,720,406	14		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	15,954	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	4,001	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	19,355	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	857	0		6.00
7.00	CHEMICAL DEPENDENCY/SAFE	31.02	0	65	0		7.00
8.00	ELECTROENCEPHALOGRAPHY	70.00	0	62	0		8.00
9.00	CLINIC	90.00	0	565,329	0		9.00
10.00	RETAIL PHARMACY	191.02	0	64	0		10.00
	TOTALS		0	2,329,694			
D - TO RECLASS LABORATORY							
1.00	ADULTS & PEDIATRICS	30.00	0	16,535	0		1.00
	TOTALS		0	16,535			
E - TO RECLASS COMMUNITY RELATION EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	61,179	62,052	0		1.00
	TOTALS		61,179	62,052			
F - TO RECLASS PROPERTY TAX							
1.00		0.00	0	0	0		1.00
2.00	CAP REL COSTS - OTHER	2.01	0	330,402	13		2.00
3.00		0.00	0	0	13		3.00
	TOTALS		0	330,402			
G - TO RECLASS LIGHT DUTY							
1.00		0.00	0	0	0		1.00
3.00	ADMINISTRATIVE & GENERAL	5.00	15,187	0	0		3.00
	TOTALS		15,187	0			
H - TO RECLASS ORIENTATION EXP							
1.00		0.00	0	0	0		1.00
3.00	ADMINISTRATIVE & GENERAL	5.00	212,402	0	0		3.00
	TOTALS		212,402	0			
I - TO RECLASS INTEREST EXP							
1.00		0.00	0	0	0		1.00
3.00	INTEREST EXPENSES	99.01	0	119,240	0		3.00
	TOTALS		0	119,240			
J - TO RECLASS INSURANCE EXP							
1.00		0.00	0	0	0		1.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	248,589	12		3.00
4.00		0.00	0	0	12		4.00
	TOTALS		0	248,589			
K - TO RECLASS TRANSPORTATION COST							
1.00	CLINIC	90.00	0	679,843	0		1.00
	TOTALS		0	679,843			
L - TO RECLASS RADIOLOGY COST							
1.00	ADULTS & PEDIATRICS	30.00	0	6,268	0		1.00
	TOTALS		0	6,268			
M - TO RECLASS NON HOSPITAL OP COST							
1.00	CLINIC	90.00	1,836,982	1,223,759	0		1.00
2.00	CLINIC	90.00	5,124	5,529	0		2.00
	TOTALS		1,842,106	1,229,288			
500.00	Grand Total: Decreases		2,130,874	5,064,951			500.00

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		
B - DEFAULT									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43,040	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	428	1.00
2.00		0.00	0		DIETARY	10.00	0	22	2.00
3.00		0.00	0		NURSING	13.00	0	47	3.00
4.00		0.00	0		ADMINISTRATION		0		
5.00		0.00	0		MEDICAL RECORDS & LIBRARY	16.00	0	268	4.00
6.00		0.00	0		SOCIAL SERVICE	17.00	0	190	5.00
7.00		0.00	0		CHEMICAL	31.02	0	13	6.00
8.00		0.00	0		DEPENDENCY/SAFE		0		
9.00		0.00	0		PHARMACY	15.00	0	424	7.00
		0.00	0		CLINIC	90.00	0	40,168	8.00
		0.00	0		RETAIL PHARMACY	191.02	0	1,480	9.00
	TOTALS		0	43,040	TOTALS		0	43,040	
C - DEFAULT									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,271,214	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,601	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	58,480	ADMINISTRATIVE & GENERAL	5.00	0	1,720,406	2.00
3.00		0.00	0		MAINTENANCE & REPAIRS	6.00	0	15,954	3.00
4.00		0.00	0		NURSING	13.00	0	4,001	4.00
5.00		0.00	0		ADMINISTRATION		0		
6.00		0.00	0		MEDICAL RECORDS & LIBRARY	16.00	0	19,355	5.00
7.00		0.00	0		ADULTS & PEDIATRICS	30.00	0	857	6.00
8.00		0.00	0		CHEMICAL	31.02	0	65	7.00
9.00		0.00	0		DEPENDENCY/SAFE		0		
10.00		0.00	0		ELECTROENCEPHALOGRAPH Y	70.00	0	62	8.00
		0.00	0		CLINIC	90.00	0	565,329	9.00
		0.00	0		RETAIL PHARMACY	191.02	0	64	10.00
	TOTALS		0	2,329,694	TOTALS		0	2,329,694	
D - TO RECLASS LABORATORY									
1.00	CHEMICAL	31.02	0	16,535	ADULTS & PEDIATRICS	30.00	0	16,535	1.00
	DEPENDENCY/SAFE		0				0		
	TOTALS		0	16,535	TOTALS		0	16,535	
E - TO RECLASS COMMUNITY RELATION EXP									
1.00	COMMUNITY RELATION	191.01	61,179	62,052	ADMINISTRATIVE & GENERAL	5.00	61,179	62,052	1.00
	TOTALS		61,179	62,052	TOTALS		61,179	62,052	
F - TO RECLASS PROPERTY TAX									
1.00		0.00	0	0		0.00	0	0	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	78,777	CAP REL COSTS - OTHER	2.01	0	330,402	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	251,625		0.00	0	0	3.00
	TOTALS		0	330,402	TOTALS		0	330,402	
G - TO RECLASS LIGHT DUTY									
1.00		0.00	0	0		0.00	0	0	1.00
3.00	ADULTS & PEDIATRICS	30.00	15,187	0	ADMINISTRATIVE & GENERAL	5.00	15,187	0	3.00
	TOTALS		15,187	0	TOTALS		15,187	0	
H - TO RECLASS ORIENTATION EXP									
1.00		0.00	0	0		0.00	0	0	1.00
3.00	ADULTS & PEDIATRICS	30.00	212,402	0	ADMINISTRATIVE & GENERAL	5.00	212,402	0	3.00
	TOTALS		212,402	0	TOTALS		212,402	0	
I - TO RECLASS INTEREST EXP									
1.00		0.00	0	0		0.00	0	0	1.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	119,240	INTEREST EXPENSES	99.01	0	119,240	3.00
	TOTALS		0	119,240	TOTALS		0	119,240	
J - TO RECLASS INSURANCE EXP									
1.00		0.00	0	0		0.00	0	0	1.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,199	ADMINISTRATIVE & GENERAL	5.00	0	248,589	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	197,390		0.00	0	0	4.00
	TOTALS		0	248,589	TOTALS		0	248,589	
K - TO RECLASS TRANSPORTATION COST									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	679,843	CLINIC	90.00	0	679,843	1.00
	TOTALS		0	679,843	TOTALS		0	679,843	

	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	
L - TO RECLASS RADIOLOGY COST									
1.00	CHEMICAL	31.02	0	6,268	ADULTS & PEDIATRICS	30.00	0	6,268	1.00
	DEPENDENCY/SAFE								
	TOTALS		0	6,268	TOTALS		0	6,268	
M - TO RECLASS NON HOSPITAL OP COST									
1.00	NON HOSPITAL OP	191.03	1,836,982	1,223,759	CLINIC	90.00	1,836,982	1,223,759	1.00
2.00	NON HOSPITAL OP	191.03	5,124	5,529	CLINIC	90.00	5,124	5,529	2.00
	TOTALS		1,842,106	1,229,288	TOTALS		1,842,106	1,229,288	
500.00	Grand Total:		2,130,874	5,064,951	Grand Total:		2,130,874	5,064,951	500.00
	Increases				Decreases				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 264012

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

worksheet A-7
Part I
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		Beginning Balances 1.00	Acquisitions			Disposals and Retirements 5.00	
			Purchases 2.00	Donation 3.00	Total 4.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	1,245,745	226,297	0	226,297	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,355,402	367,667	0	367,667	21,148	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,601,147	593,964	0	593,964	21,148	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	5,601,147	593,964	0	593,964	21,148	10.00
		Ending Balance 6.00	Fully Depreciated Assets 7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	1,472,042	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4,701,921	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	6,173,963	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	6,173,963	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 264012

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

Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	140,627	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	552,657	0	0	0	0	2.00
2.01	CAP REL COSTS - OTHER	0	0	0	0	330,402	2.01
3.00	Total (sum of lines 1-2)	693,284	0	0	0	330,402	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	140,627	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	552,657	2.00
2.01	CAP REL COSTS - OTHER	0	330,402	2.01
3.00	Total (sum of lines 1-2)	0	1,023,686	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 264012

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

Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,472,042	0	1,472,042	0.238427	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,701,922	0	4,701,922	0.761573	0	2.00
2.01	CAP REL COSTS - OTHER	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	6,173,964	0	6,173,964	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	140,627	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	552,657	0	2.00
2.01	CAP REL COSTS - OTHER	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	693,284	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	51,199	78,777	2,271,214	2,541,817	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	197,390	251,625	58,480	1,060,152	2.00
2.01	CAP REL COSTS - OTHER	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	248,589	330,402	2,329,694	3,601,969	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		
				Cost Center	Line #	Wkst. A-7 Ref.
				1.00	2.00	3.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
2.01	Investment income - CAP REL COSTS - OTHER (chapter 2)		0	CAP REL COSTS - OTHER	2.01	0 2.01
3.00	Investment income - other (chapter 2)		0		0.00	0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0 7.00
8.00	Television and radio service (chapter 21)		0		0.00	0 8.00
9.00	Parking lot (chapter 21)		0		0.00	0 9.00
10.00	Provider-based physician adjustment	A-8-2	-3,815,590			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	0			0 12.00
13.00	Laundry and linen service		0		0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-73,394	DIETARY	10.00	0 14.00
15.00	Rental of quarters to employee and others		0		0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00	Sale of drugs to other than patients		0		0.00	0 17.00
18.00	Sale of medical records and abstracts	B	-4,244	MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0 19.00
20.00	Vending machines	A	-9,626	DIETARY	10.00	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	*** Cost Center Deleted ***	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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
27.01	Depreciation - CAP REL COSTS - OTHER		0	CAP REL COSTS - OTHER	2.01	0 27.01
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	*** Cost Center Deleted ***	67.00	30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00	30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00

Provider CCN: 264012

Period:
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Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 INTEREST INCOME	B	-2,392	ADMINISTRATIVE & GENERAL	5.00		0	33.00
33.01 SERVICE AGREEMENT	B	-296,069	ADMINISTRATIVE & GENERAL	5.00		0	33.01
33.02 LOBBYING EXPENSES PER MHA	A	-11,442	ADMINISTRATIVE & GENERAL	5.00		0	33.02
33.03 FRA EXPENSE	A	1,952,988	ADMINISTRATIVE & GENERAL	5.00		0	33.03
33.05 BAD DEBT EXPENSES	A	-3,335,018	ADMINISTRATIVE & GENERAL	5.00		0	33.05
33.06 CD EDUCATIONAL INCOME	B	-100	CHEMICAL DEPENDENCY/SAFE	31.02		0	33.06
33.07 GAIN ON SALE	B	-3,700	ADMINISTRATIVE & GENERAL	5.00		0	33.07
33.08 DONATIONS	B	-35,447	ADMINISTRATIVE & GENERAL	5.00		0	33.08
33.09 OTHER INCOME	B	-45,014	ADMINISTRATIVE & GENERAL	5.00		0	33.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-5,679,048					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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 264012

Period:
From 01/01/2014
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Worksheet A-8-2

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1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
1.00	5.00 ADMINISTRATIVE & GENERAL	3,076,728	0	0	0	0	1.00
2.00	30.00 ADULTS & PEDIATRICS	274,386	0	0	0	0	2.00
3.00	31.02 CHEMICAL DEPENDENCY/SAFE	104,700	0	0	0	0	3.00
4.00	90.00 CLINIC	359,776	0	0	0	0	4.00
5.00	0.00	0	0	0	0	0	5.00
6.00	0.00	0	0	0	0	0	6.00
7.00	0.00	0	0	0	0	0	7.00
8.00	0.00	0	0	0	0	0	8.00
9.00	0.00	0	0	0	0	0	9.00
10.00	0.00	0	0	0	0	0	10.00
200.00		3,815,590	0	0	0	0	200.00

1.00	2.00	8.00	9.00	12.00	13.00	14.00	15.00
1.00	2.00	8.00	9.00	12.00	13.00	14.00	15.00
1.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.02 CHEMICAL DEPENDENCY/SAFE	0	0	0	0	0	3.00
4.00	90.00 CLINIC	0	0	0	0	0	4.00
5.00	0.00	0	0	0	0	0	5.00
6.00	0.00	0	0	0	0	0	6.00
7.00	0.00	0	0	0	0	0	7.00
8.00	0.00	0	0	0	0	0	8.00
9.00	0.00	0	0	0	0	0	9.00
10.00	0.00	0	0	0	0	0	10.00
200.00		0	0	0	0	0	200.00

1.00	2.00	15.00	16.00	17.00	18.00	19.00	20.00
1.00	2.00	15.00	16.00	17.00	18.00	19.00	20.00
1.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	3,076,728		1.00
2.00	30.00 ADULTS & PEDIATRICS	0	0	0	274,386		2.00
3.00	31.02 CHEMICAL DEPENDENCY/SAFE	0	0	0	104,700		3.00
4.00	90.00 CLINIC	0	0	0	359,776		4.00
5.00	0.00	0	0	0	0		5.00
6.00	0.00	0	0	0	0		6.00
7.00	0.00	0	0	0	0		7.00
8.00	0.00	0	0	0	0		8.00
9.00	0.00	0	0	0	0		9.00
10.00	0.00	0	0	0	0		10.00
200.00		0	0	0	3,815,590		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

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

worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP	CAP REL COSTS - OTHER		
	0	1.00	2.00	2.01	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,541,817	2,541,817			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,060,152		1,060,152		2.00
2.01 00201	CAP REL COSTS - OTHER	0		0	0	2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,388,124	39,237	16,365	5,443,726	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,131,265	220,264	91,868	988,312	5.00
6.00 00600	MAINTENANCE & REPAIRS	854,781	83,243	34,719	67,439	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	109,687	16,513	6,887	0	8.00
9.00 00900	HOUSEKEEPING	382,707	20,781	8,668	0	9.00
10.00 01000	DIETARY	1,192,371	208,813	87,093	93,398	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	836,131	17,838	7,440	229,361	13.00
15.00 01500	PHARMACY	1,043,567	10,155	4,236	67,173	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	623,044	16,484	6,875	123,567	16.00
17.00 01700	SOCIAL SERVICE	546,515	14,099	5,881	151,807	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,923,436	1,002,356	418,068	2,023,493	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01 02400	OTHER SPECIAL CARE (SPECIFY)	0	0	0	0	31.01
31.02 03101	CHEMICAL DEPENDENCY/SAFE	1,562,034	284,874	118,816	390,819	31.02
ANCILLARY SERVICE COST CENTERS						
70.00 07000	ELECTROENCEPHALOGRAPHY	312,644	50,746	21,165	37,167	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,497,826	286,905	119,663	593,896	90.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	99.00
99.01 09901	INTEREST EXPENSES	0	0	0	0	99.01
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,006,101	2,272,308	947,744	4,766,432	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	0	0	0	0	191.00
191.01 19101	COMMUNITY RELATION	123,231	1,766	737	34,810	191.01
191.02 19102	RETAIL PHARMACY	3,744,535	26,551	11,074	122,124	191.02
191.03 19103	NON HOSPITAL OP	3,071,394	241,192	100,597	520,360	191.03
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	41,945,261	2,541,817	1,060,152	5,443,726	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

Period:
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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	6.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500	9,431,709	9,431,709				5.00
6.00	00600	1,040,182	301,741	1,341,923			6.00
8.00	00800	133,087	38,607	12,221	183,915		8.00
9.00	00900	412,156	119,560	15,380	0	547,096	9.00
10.00	01000	1,581,675	458,820	154,536	0	64,327	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	1,090,770	316,416	13,201	0	5,495	13.00
15.00	01500	1,125,131	326,384	7,516	0	3,128	15.00
16.00	01600	769,970	223,357	12,199	0	5,078	16.00
17.00	01700	718,302	208,369	10,435	0	4,343	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,367,353	3,297,514	741,813	148,325	308,786	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	02400	0	0	0	0	0	31.01
31.02	03101	2,356,543	683,598	210,827	35,590	87,758	31.02
ANCILLARY SERVICE COST CENTERS							
70.00	07000	421,722	122,335	37,556	0	15,633	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	3,498,290	1,014,801	105,283	0	43,825	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.01	09901	0	0	0	0	0	99.01
SPECIAL PURPOSE COST CENTERS							
118.00		33,946,890	7,111,502	1,320,967	183,915	538,373	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
191.01	19101	160,544	46,571	1,307	0	544	191.01
191.02	19102	3,904,284	1,132,574	19,649	0	8,179	191.02
191.03	19103	3,933,543	1,141,062	0	0	0	191.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		41,945,261	9,431,709	1,341,923	183,915	547,096	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

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

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY		
		10.00	11.00	13.00	15.00	16.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
2.01	00201						2.01	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000	2,259,358					10.00	
11.00	01100	393,724	393,724				11.00	
13.00	01300	0	20,664	1,446,546			13.00	
15.00	01500	0	5,585	0	1,467,744		15.00	
16.00	01600	0	20,850	0	0	1,031,454	16.00	
17.00	01700	0	19,919	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	1,379,638	237,164	1,166,622	0	939,360	30.00	
31.00	03100	0	0	0	0	0	31.00	
31.01	02400	0	0	0	0	0	31.01	
31.02	03101	236,748	55,289	279,924	0	46,047	31.02	
ANCILLARY SERVICE COST CENTERS								
70.00	07000	0	4,468	0	0	0	70.00	
73.00	07300	0	0	0	1,467,744	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	249,248	29,785	0	0	27,628	90.00	
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	0	0	0	0	0	99.00	
99.01	09901	0	0	0	0	0	99.01	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		2,259,358	393,724	1,446,546	1,467,744	1,013,035	118.00
NONREIMBURSABLE COST CENTERS								
191.00	19100	0	0	0	0	0	191.00	
191.01	19101	0	0	0	0	0	191.01	
191.02	19102	0	0	0	0	0	191.02	
191.03	19103	0	0	0	0	18,419	191.03	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	TOTAL (sum lines 118-201)		2,259,358	393,724	1,446,546	1,467,744	1,031,454	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 264012

Period:
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
2.01	00201	CAP REL COSTS - OTHER				4.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				5.00
5.00	00500	ADMINISTRATIVE & GENERAL				6.00
6.00	00600	MAINTENANCE & REPAIRS				8.00
8.00	00800	LAUNDRY & LINEN SERVICE				9.00
9.00	00900	HOUSEKEEPING				10.00
10.00	01000	DIETARY				11.00
11.00	01100	CAFETERIA				13.00
13.00	01300	NURSING ADMINISTRATION				15.00
15.00	01500	PHARMACY				16.00
16.00	01600	MEDICAL RECORDS & LIBRARY				17.00
17.00	01700	SOCIAL SERVICE	961,368			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	920,284	20,506,859	0	20,506,859
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0
31.01	02400	OTHER SPECIAL CARE (SPECIFY)	0	0	0	0
31.02	03101	CHEMICAL DEPENDENCY/SAFE	41,084	4,033,408	0	4,033,408
ANCILLARY SERVICE COST CENTERS						
70.00	07000	ELECTROENCEPHALOGRAPHY	0	601,714	0	601,714
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,467,744	0	1,467,744
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,968,860	0	4,968,860
OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0
99.01	09901	INTEREST EXPENSES	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	961,368	31,578,585	0	31,578,585
NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	0
191.01	19101	COMMUNITY RELATION	0	208,966	0	208,966
191.02	19102	RETAIL PHARMACY	0	5,064,686	0	5,064,686
191.03	19103	NON HOSPITAL OP	0	5,093,024	0	5,093,024
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	961,368	41,945,261	0	41,945,261

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
2.01	CAP REL COSTS - OTHER	0	SQUARE FEET	2.01
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	2	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	3	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	2	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	6	PAID FTE'S	11.00
13.00	NURSING ADMINISTRATION	3	PATIENT DAYS	13.00
15.00	PHARMACY	15	PCT OF UTILZ	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal		
		BLDG & FIXT	MVBLE EQUIP	CAP REL COSTS - OTHER			
		0	1.00	2.00		2.01	2A
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00		
2.01 00201	CAP REL COSTS - OTHER				2.01		
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	39,237	16,365	0	55,602	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	220,264	91,868	0	312,132	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	83,243	34,719	0	117,962	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	16,513	6,887	0	23,400	8.00
9.00 00900	HOUSEKEEPING	0	20,781	8,668	0	29,449	9.00
10.00 01000	DIETARY	0	208,813	87,093	0	295,906	10.00
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	17,838	7,440	0	25,278	13.00
15.00 01500	PHARMACY	0	10,155	4,236	0	14,391	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	16,484	6,875	0	23,359	16.00
17.00 01700	SOCIAL SERVICE	0	14,099	5,881	0	19,980	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	1,002,356	418,068	0	1,420,424	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01 02400	OTHER SPECIAL CARE (SPECIFY)	0	0	0	0	0	31.01
31.02 03101	CHEMICAL DEPENDENCY/SAFE	0	284,874	118,816	0	403,690	31.02
ANCILLARY SERVICE COST CENTERS							
70.00 07000	ELECTROENCEPHALOGRAPHY	0	50,746	21,165	0	71,911	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	286,905	119,663	0	406,568	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00 09900	CMHC	0	0	0	0	0	99.00
99.01 09901	INTEREST EXPENSES	0	0	0	0	0	99.01
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,272,308	947,744	0	3,220,052	118.00
NONREIMBURSABLE COST CENTERS							
191.00 19100	RESEARCH	0	0	0	0	0	191.00
191.01 19101	COMMUNITY RELATION	0	1,766	737	0	2,503	191.01
191.02 19102	RETAIL PHARMACY	0	26,551	11,074	0	37,625	191.02
191.03 19103	NON HOSPITAL OP	0	241,192	100,597	0	341,789	191.03
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers					0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,541,817	1,060,152	0	3,601,969	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMINISTRATIVE & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400	55,602					4.00
5.00	00500	10,094	322,226				5.00
6.00	00600	689	10,309	128,960			6.00
8.00	00800	0	1,319	1,174	25,893		8.00
9.00	00900	0	4,085	1,478	0	35,012	9.00
10.00	01000	954	15,676	14,851	0	4,117	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	2,342	10,811	1,269	0	352	13.00
15.00	01500	686	11,151	722	0	200	15.00
16.00	01600	1,262	7,631	1,172	0	325	16.00
17.00	01700	1,550	7,119	1,003	0	278	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	20,671	112,646	71,289	20,882	19,761	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	02400	0	0	0	0	0	31.01
31.02	03101	3,991	23,356	20,261	5,011	5,616	31.02
ANCILLARY SERVICE COST CENTERS							
70.00	07000	380	4,180	3,609	0	1,000	70.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	6,066	34,672	10,118	0	2,805	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.01	09901	0	0	0	0	0	99.01
SPECIAL PURPOSE COST CENTERS							
118.00		48,685	242,955	126,946	25,893	34,454	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
191.01	19101	356	1,591	126	0	35	191.01
191.02	19102	1,247	38,695	1,888	0	523	191.02
191.03	19103	5,314	38,985	0	0	0	191.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		55,602	322,226	128,960	25,893	35,012	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

Period:
From 01/01/2014
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	331,504					10.00
11.00	01100	57,769	57,769				11.00
13.00	01300	0	3,032	43,084			13.00
15.00	01500	0	819	0	27,969		15.00
16.00	01600	0	3,059	0	0	36,808	16.00
17.00	01700	0	2,923	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	202,427	34,798	34,747	0	33,522	30.00
31.00	03100	0	0	0	0	0	31.00
31.01	02400	0	0	0	0	0	31.01
31.02	03101	34,737	8,112	8,337	0	1,643	31.02
ANCILLARY SERVICE COST CENTERS							
70.00	07000	0	656	0	0	0	70.00
73.00	07300	0	0	0	27,969	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	36,571	4,370	0	0	986	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.01	09901	0	0	0	0	0	99.01
SPECIAL PURPOSE COST CENTERS							
118.00		331,504	57,769	43,084	27,969	36,151	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
191.01	19101	0	0	0	0	0	191.01
191.02	19102	0	0	0	0	0	191.02
191.03	19103	0	0	0	0	657	191.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		331,504	57,769	43,084	27,969	36,808	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 264012

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

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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		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	
2.01	00201	CAP REL COSTS - OTHER				2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
6.00	00600	MAINTENANCE & REPAIRS				6.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	32,853			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,449	2,002,616	0	2,002,616	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	02400	OTHER SPECIAL CARE (SPECIFY)	0	0	0	0	31.01
31.02	03101	CHEMICAL DEPENDENCY/SAFE	1,404	516,158	0	516,158	31.02
ANCILLARY SERVICE COST CENTERS							
70.00	07000	ELECTROENCEPHALOGRAPHY	0	81,736	0	81,736	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	27,969	0	27,969	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	502,156	0	502,156	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	99.00
99.01	09901	INTEREST EXPENSES	0	0	0	0	99.01
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,853	3,130,635	0	3,130,635	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	0	0	0	0	191.00
191.01	19101	COMMUNITY RELATION	0	4,611	0	4,611	191.01
191.02	19102	RETAIL PHARMACY	0	79,978	0	79,978	191.02
191.03	19103	NON HOSPITAL OP	0	386,745	0	386,745	191.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	32,853	3,601,969	0	3,601,969	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C
Part I
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	20,506,859		20,506,859	0	20,506,859
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0
31.01	02400 OTHER SPECIAL CARE (SPECIFY)	0		0	0	0
31.02	03101 CHEMICAL DEPENDENCY/SAFE	4,033,408		4,033,408	0	4,033,408
ANCILLARY SERVICE COST CENTERS						
70.00	07000 ELECTROENCEPHALOGRAPHY	601,714		601,714	0	601,714
73.00	07300 DRUGS CHARGED TO PATIENTS	1,467,744		1,467,744	0	1,467,744
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	4,968,860		4,968,860	0	4,968,860
OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC	0		0		0
99.01	09901 INTEREST EXPENSES	0		0		0
200.00	Subtotal (see instructions)	31,578,585	0	31,578,585	0	31,578,585
201.00	Less Observation Beds	0		0		0
202.00	Total (see instructions)	31,578,585	0	31,578,585	0	31,578,585

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

Period:
From 01/01/2014
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Worksheet C
Part I
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Title XVIII

Hospital

PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	26,841,570		26,841,570			30.00
31.00 03100 INTENSIVE CARE UNIT	0		0			31.00
31.01 02400 OTHER SPECIAL CARE (SPECIFY)	0		0			31.01
31.02 03101 CHEMICAL DEPENDENCY/SAFE	3,831,565		3,831,565			31.02
ANCILLARY SERVICE COST CENTERS						
70.00 07000 ELECTROENCEPHALOGRAPHY	1,458,716	2,227,660	3,686,376	0.163226	0.000000	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4,090,579	218,837	4,309,416	0.340590	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	53,090	20,810,315	20,863,405	0.238162	0.000000	90.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0	0			99.00
99.01 09901 INTEREST EXPENSES	0	0	0			99.01
200.00 Subtotal (see instructions)	36,275,520	23,256,812	59,532,332			200.00
201.00 Less observation Beds						201.00
202.00 Total (see instructions)	36,275,520	23,256,812	59,532,332			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C
Part I
Date/Time Prepared:
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Title XVIII

Hospital

PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
31.01	02400 OTHER SPECIAL CARE (SPECIFY)		31.01
31.02	03101 CHEMICAL DEPENDENCY/SAFE		31.02
ANCILLARY SERVICE COST CENTERS			
70.00	07000 ELECTROENCEPHALOGRAPHY	0.163226	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.340590	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.238162	90.00
OTHER REIMBURSABLE COST CENTERS			
99.00	09900 CMHC		99.00
99.01	09901 INTEREST EXPENSES		99.01
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: 264012

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	20,506,859		20,506,859	0	20,506,859	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
31.01	02400 OTHER SPECIAL CARE (SPECIFY)	0		0	0	0	31.01
31.02	03101 CHEMICAL DEPENDENCY/SAFE	4,033,408		4,033,408	0	4,033,408	31.02
ANCILLARY SERVICE COST CENTERS							
70.00	07000 ELECTROENCEPHALOGRAPHY	601,714		601,714	0	601,714	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,467,744		1,467,744	0	1,467,744	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	4,968,860		4,968,860	0	4,968,860	90.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0		0		0	99.00
99.01	09901 INTEREST EXPENSES	0		0		0	99.01
200.00	Subtotal (see instructions)	31,578,585	0	31,578,585	0	31,578,585	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	31,578,585	0	31,578,585	0	31,578,585	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	26,841,570		26,841,570			30.00
31.00 03100 INTENSIVE CARE UNIT	0		0			31.00
31.01 02400 OTHER SPECIAL CARE (SPECIFY)	0		0			31.01
31.02 03101 CHEMICAL DEPENDENCY/SAFE	3,831,565		3,831,565			31.02
ANCILLARY SERVICE COST CENTERS						
70.00 07000 ELECTROENCEPHALOGRAPHY	1,458,716	2,227,660	3,686,376	0.163226	0.000000	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4,090,579	218,837	4,309,416	0.340590	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	53,090	20,810,315	20,863,405	0.238162	0.000000	90.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0	0			99.00
99.01 09901 INTEREST EXPENSES	0	0	0			99.01
200.00 Subtotal (see instructions)	36,275,520	23,256,812	59,532,332			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	36,275,520	23,256,812	59,532,332			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 264012

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

Worksheet C
Part I
Date/Time Prepared:
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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
31.01	02400 OTHER SPECIAL CARE (SPECIFY)				31.01
31.02	03101 CHEMICAL DEPENDENCY/SAFE				31.02
ANCILLARY SERVICE COST CENTERS					
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900 CMHC				99.00
99.01	09901 INTEREST EXPENSES				99.01
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: 264012

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

Worksheet D
Part I
Date/Time Prepared:
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,002,616	0	2,002,616	29,882	67.02	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
31.01	OTHER SPECIAL CARE (SPECIFY)	0		0	0	0.00	31.01
31.02	CHEMICAL DEPENDENCY/SAFE	516,158		516,158	7,170	71.99	31.02
200.00	Total (lines 30-199)	2,518,774		2,518,774	37,052		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,343	492,128				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
31.01	OTHER SPECIAL CARE (SPECIFY)	0	0				31.01
31.02	CHEMICAL DEPENDENCY/SAFE	0	0				31.02
200.00	Total (lines 30-199)	7,343	492,128				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 264012

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

Worksheet D
Part II
Date/Time Prepared:
5/27/2015 11:33 am

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)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
70.00	07000 ELECTROENCEPHALOGRAPHY	81,736	3,686,376	0.022172	612,801	13,587	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	27,969	4,309,416	0.006490	1,324,614	8,597	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	502,156	20,863,405	0.024069	300	7	90.00
200.00	Total (lines 50-199)	611,861	28,859,197		1,937,715	22,191	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 264012	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part III Date/Time Prepared: 5/27/2015 11:33 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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	02400	OTHER SPECIAL CARE (SPECIFY)	0	0	0	0	31.01
31.02	03101	CHEMICAL DEPENDENCY/SAFE	0	0	0	0	31.02
200.00		Total (lines 30-199)	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	29,882	0.00	7,343	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	31.00
31.01	02400	OTHER SPECIAL CARE (SPECIFY)	0	0.00	0	0	31.01
31.02	03101	CHEMICAL DEPENDENCY/SAFE	7,170	0.00	0	0	31.02
200.00		Total (lines 30-199)	37,052		7,343	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
31.01	02400	OTHER SPECIAL CARE (SPECIFY)	0	0			31.01
31.02	03101	CHEMICAL DEPENDENCY/SAFE	0	0			31.02
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
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: 264012

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,686,376	0.000000	0.000000	612,801	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,309,416	0.000000	0.000000	1,324,614	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	20,863,405	0.000000	0.000000	300	90.00
200.00		Total (lines 50-199)	0	28,859,197			1,937,715	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
70.00	07000 ELECTROENCEPHALOGRAPHY	0	667,222	0	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	832	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	18,217,460	0	0	0	90.00
200.00	Total (lines 50-199)	0	18,885,514	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 264012

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

worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 264012

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

Worksheet D
Part V
Date/Time Prepared:
5/27/2015 11:33 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								
70.00	07000	ELECTROENCEPHALOGRAPHY	0.163226	667,222	0	0	108,908	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340590	832	0	0	283	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.238162	18,217,460	0	0	4,338,707	90.00
200.00		Subtotal (see instructions)		18,885,514	0	0	4,447,898	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		18,885,514	0	0	4,447,898	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 264012

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

Worksheet D
Part V
Date/Time Prepared:
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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					
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet D-1

Date/Time Prepared:
5/27/2015 11:33 am

		Title XVIII	Hospital	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)			29,882 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			29,882 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)			29,882 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)			7,343 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)			20,506,859 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)			20,506,859 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 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)			20,506,859 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)			686.26 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			5,039,207 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)			5,039,207 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet D-1

Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description	Title XVIII			Hospital	PPS	
	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01 OTHER SPECIAL CARE (SPECIFY)	0	0	0.00	0	0	43.01
43.02 CHEMICAL DEPENDENCY/SAFE	4,033,408	7,170	562.54	0	0	43.02
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)					1.00	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					551,246	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)					492,128	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					22,191	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					514,319	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,076,134	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: 264012

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

worksheet D-1
Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description	Title XVIII			Hospital	PPS
	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	2,002,616	20,506,859	0.097656	0	0 90.00
91.00 Nursing School cost	0	20,506,859	0.000000	0	0 91.00
92.00 Allied health cost	0	20,506,859	0.000000	0	0 92.00
93.00 All other Medical Education	0	20,506,859	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet D-1

Date/Time Prepared:
5/27/2015 11:33 am

Title XIX		Hospital	Cost
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)	29,882	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,882	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)	29,882	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)	4,362	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)	20,506,859	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)	20,506,859	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)	20,506,859	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)	686.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,993,466	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,993,466	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 264012

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

Worksheet D-1
Date/Time Prepared:
5/27/2015 11:33 am

		Title XIX			Hospital	Cost	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	0	0	0.00	0	0	43.00	
43.01	0	0	0.00	0	0	43.01	
43.02	4,033,408	7,170	562.54	0	0	43.02	
44.00						44.00	
45.00						45.00	
46.00						46.00	
47.00						47.00	
Cost Center Description					1.00		
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					132,241	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,125,707	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)					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: 264012

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

worksheet D-1
Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description	Title XIX			Hospital	Cost	
	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	2,002,616	20,506,859	0.097656	0	0	90.00
91.00 Nursing School cost	0	20,506,859	0.000000	0	0	91.00
92.00 Allied health cost	0	20,506,859	0.000000	0	0	92.00
93.00 All other Medical Education	0	20,506,859	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 264012

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

Worksheet D-3

Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,723,360		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	02400 OTHER SPECIAL CARE (SPECIFY)		0		31.01
31.02	03101 CHEMICAL DEPENDENCY/SAFE		0		31.02
ANCILLARY SERVICE COST CENTERS					
70.00	07000 ELECTROENCEPHALOGRAPHY	0.163226	612,801	100,025	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.340590	1,324,614	451,150	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.238162	300	71	90.00
200.00	Total (sum of lines 50-94 and 96-98)		1,937,715	551,246	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)		1,937,715		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 264012

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

Worksheet D-3

Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		3,838,560		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
31.01	02400 OTHER SPECIAL CARE (SPECIFY)		0		31.01
31.02	03101 CHEMICAL DEPENDENCY/SAFE		0		31.02
ANCILLARY SERVICE COST CENTERS					
70.00	07000 ELECTROENCEPHALOGRAPHY	0.163226	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.340590	388,271	132,241	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.238162	0	0	90.00
200.00	Total (sum of lines 50-94 and 96-98)		388,271	132,241	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)		388,271		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 264012

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

Worksheet E
Part B
Date/Time Prepared:
5/27/2015 11:33 am

Title XVIII		Hospital	PPS
			1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,447,898	2.00
3.00	PPS payments	5,889,276	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	5,889,276	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00	Deductibles and coinsurance (for CAH, see instructions)	1,189,350	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	4,699,926	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)	4,699,926	30.00
31.00	Primary payer payments	15,940	31.00
32.00	Subtotal (line 30 minus line 31)	4,683,986	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)	581,782	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	378,158	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	221,496	36.00
37.00	Subtotal (see instructions)	5,062,144	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)	5,062,144	40.00
40.01	Sequestration adjustment (see instructions)	101,243	40.01
41.00	Interim payments	4,590,181	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	370,720	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: 264012

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2015 11:33 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		4,698,488		4,590,181	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	12/31/2014	110,900		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)		110,900		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)		4,809,388		4,590,181	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		109,595		370,720	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,918,983		4,960,901	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

Provider CCN: 264012

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

Worksheet E-3
Part II
Date/Time Prepared:
5/27/2015 11:33 am

		Title XVIII	Hospital	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)		5,420,506	1.00
2.00	Net IPF PPS Outlier Payments		9,769	2.00
3.00	Net IPF PPS ECT Payments		28,372	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)		81,868,493	9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9}))^{\text{raised to the power of } .5150 - 1}\}$.		0.0000000	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)		5,458,647	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)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		5,458,647	16.00
17.00	Primary payer payments		30,552	17.00
18.00	Subtotal (line 16 less line 17).		5,428,095	18.00
19.00	Deductibles		423,338	19.00
20.00	Subtotal (line 18 minus line 19)		5,004,757	20.00
21.00	Coinsurance		210,368	21.00
22.00	Subtotal (line 20 minus line 21)		4,794,389	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		346,124	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		224,981	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		243,851	25.00
26.00	Subtotal (sum of lines 22 and 24)		5,019,370	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	INTEREST PAYMENTS		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)		5,019,370	31.00
31.01	Sequestration adjustment (see instructions)		100,387	31.01
32.00	Interim payments		4,809,388	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)		109,595	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		9,769	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 264012

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

Worksheet E-3
Part VII
Date/Time Prepared:
5/27/2015 11:33 am

		Title XIX		Hospital		Cost	
				Inpatient	Outpatient		
				1.00	2.00		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES							
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient hospital/SNF/NF services			3,125,707		0	1.00
2.00	Medical and other services					0	2.00
3.00	Organ acquisition (certified transplant centers only)			0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)			3,125,707		0	4.00
5.00	Inpatient primary payer payments			1,547,853			5.00
6.00	Outpatient primary payer payments					0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)			1,577,854		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES							
Reasonable Charges							
8.00	Routine service charges			4,226,831			8.00
9.00	Ancillary service charges			388,271		0	9.00
10.00	Organ acquisition charges, net of revenue			0			10.00
11.00	Incentive from target amount computation			0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)			4,615,102		0	12.00
CUSTOMARY CHARGES							
13.00	Amount actually collected from patients liable for payment for services on a charge basis			0		0	13.00
14.00	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		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)			4,615,102		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			1,489,395		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			0		0	18.00
19.00	Interns and Residents (see instructions)			0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)			0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)			3,125,707		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.							
22.00	Other than outlier payments			0		0	22.00
23.00	Outlier payments			0		0	23.00
24.00	Program capital payments			0		0	24.00
25.00	Capital exception payments (see instructions)			0		0	25.00
26.00	Routine and Ancillary service other pass through costs			0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)			0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)			0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)			3,125,707		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT							
30.00	Excess of reasonable cost (from line 18)			0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			1,577,854		0	31.00
32.00	Deductibles			0		0	32.00
33.00	Coinsurance			0		0	33.00
34.00	Allowable bad debts (see instructions)			0		0	34.00
35.00	Utilization review			0		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			1,577,854		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		0	37.00
38.00	Subtotal (line 36 ± line 37)			1,577,854		0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)			0		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)			1,577,854		0	40.00
41.00	Interim payments			1,547,853		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)			30,001		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2			0		0	43.00
OVERRIDES							
109.00	Override Ancillary service charges (line 9)					0	109.00

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

Provider CCN: 264012

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

Worksheet G

Date/Time Prepared: 5/27/2015 11:33 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	-733,409	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,804,899	0	0	0	4.00
5.00	Other receivable	3,385,478	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,914,345	0	0	0	6.00
7.00	Inventory	540,542	0	0	0	7.00
8.00	Prepaid expenses	229,026	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)	12,312,191	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,472,042	0	0	0	17.00
18.00	Accumulated depreciation	-593,609	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	355,473	0	0	0	21.00
22.00	Accumulated depreciation	-326,578	0	0	0	22.00
23.00	Major movable equipment	4,346,448	0	0	0	23.00
24.00	Accumulated depreciation	-3,335,481	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)	1,918,295	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	200,144	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	34,585	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	234,729	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,465,215	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,137,350	0	0	0	37.00
38.00	Salaries, wages, and fees payable	766,478	0	0	0	38.00
39.00	Payroll taxes payable	251,373	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	6,391	0	0	0	43.00
44.00	Other current liabilities	945,441	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,107,033	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	5,400,000	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,400,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,507,033	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,958,182	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,958,182	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,465,215	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 264012

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

worksheet G-1
Date/Time Prepared:
5/27/2015 11:33 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		6,334,914			0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		-376,732			0	2.00
3.00	Total (sum of line 1 and line 2)		5,958,182				3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		5,958,182			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,958,182			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 264012

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2015 11:33 am

Cost Center Description		Inpatient 1.00	Outpatient 2.00	Total 3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	26,622,330		26,622,330	1.00
2.00	SUBPROVIDER - IPF				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)	26,622,330		26,622,330	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
11.01	OTHER SPECIAL CARE (SPECIFY)	0		0	11.01
11.02	CHEMICAL DEPENDENCY/SAFE	3,831,565		3,831,565	11.02
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,831,565		3,831,565	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,453,895		30,453,895	17.00
18.00	Ancillary services	5,821,625	2,446,497	8,268,122	18.00
19.00	Outpatient services	0	20,810,315	20,810,315	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		0	0	24.00
24.01	INTEREST EXPENSES	0	0	0	24.01
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON HOSPITAL OP	0	25,979,402	25,979,402	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	36,275,520	49,236,214	85,511,734	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		47,624,309		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		47,624,309		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 264012

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

worksheet G-3

Date/Time Prepared:
5/27/2015 11:33 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	85,511,734	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,734,143	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,777,591	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	47,624,309	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-846,718	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	35,447	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	73,394	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	4,244	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	100	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	9,626	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	SERVICE AGREEMENT	296,069	24.00
24.01	GAIN ON SALE	3,700	24.01
24.02	INTEREST INCOME	2,392	24.02
24.03	OTHER INCOME	45,014	24.03
25.00	Total other income (sum of lines 6-24)	469,986	25.00
26.00	Total (line 5 plus line 25)	-376,732	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)	-376,732	29.00