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: 151317	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/28/2015 2:23 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/28/2015 Time: 2:23 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 GREENE COUNTY GENERAL HOSPITAL (151317) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	83,619	-178,151	256,608	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	31,291	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	114,910	-178,151	256,608	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/28/2015 2:21 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street:R.R 1	PO Box:1000			1.00
2.00	City: LINTON	State: IN	Zip Code: 47441-9457	County: GREENE	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	GREENE COUNTY GENERAL HOSPITAL	151317	99915	1	02/03/2003	N	O	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	GREENE COUNTY GENERAL HOSPITAL	15Z317	99915		02/03/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	9		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		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.	0		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 days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 2:21 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 2:21 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
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: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 2:21 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

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		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	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)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	75,462	0	0	118.01

		1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N	118.02
119.00	DO NOT USE THIS LINE		119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00

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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

		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	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	323,026	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151317	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 2:21 pm

		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)	01/01/2014	12/31/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2015 2:21 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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)		Y	03/23/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2015 2:21 pm

		Description	Part A Y/N	Part A Date	Part B 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				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NICHOLAS	EICHELMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000	NEICHELMAN@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/28/2015 2:21 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	03/23/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/28/2015 2:21 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	55,536.00	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)		20	7,300	55,536.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	55,536.00	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					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2015 2:21 pm

	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)	1,348	37	2,314			1.00
2.00	HMO and other (see instructions)	0	120				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	391	0	391			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	8			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,739	37	2,713			7.00
8.00	INTENSIVE CARE UNIT	318	17	447			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		42	161			13.00
14.00	Total (see instructions)	2,057	96	3,321	0.00	232.20	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						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	232.20	27.00
28.00	Observation Bed Days		374	1,164			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	38	164			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: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/28/2015 2:21 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	491	75	751	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	491	75	751	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						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/28/2015 2:21 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.418182	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,512,194	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,275,893	5.00
6.00	Medicaid charges	8,777,103	6.00
7.00	Medicaid cost (line 1 times line 6)	3,670,426	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	576,027	160,276	736,303	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	240,884	67,025	307,909	21.00
22.00	Partial payment by patients approved for charity care	11,817	13,286	25,103	22.00
23.00	Cost of charity care (line 21 minus line 22)	229,067	53,739	282,806	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,771,687	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	129,737	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,641,950	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,941,180	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,223,986	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,223,986	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/28/2015 2:21 pm

		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	CAP REL COSTS-BLDG & FIXT		1,008,897	1,008,897	42,318	1,051,215	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		413,687	413,687	2,113	415,800	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,181,831	4,181,831	-47,230	4,134,601	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,560,996	3,788,397	5,349,393	-305,289	5,044,104	5.00
7.00	00700	OPERATION OF PLANT	424,842	971,566	1,396,408	0	1,396,408	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	179,065	179,065	0	179,065	8.00
9.00	00900	HOUSEKEEPING	366,921	84,379	451,300	0	451,300	9.00
10.00	01000	DIETARY	493,828	531,929	1,025,757	-901,740	124,017	10.00
11.00	01100	CAFETERIA	0	0	0	901,740	901,740	11.00
13.00	01300	NURSING ADMINISTRATION	579,149	113,723	692,872	0	692,872	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	155,445	155,445	0	155,445	14.00
15.00	01500	PHARMACY	456,342	88,738	545,080	0	545,080	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	235,433	10,736	246,169	0	246,169	16.00
17.00	01700	SOCIAL SERVICE	143,789	0	143,789	0	143,789	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	429,852	429,852	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,413,546	697,398	3,110,944	88,433	3,199,377	30.00
31.00	03100	INTENSIVE CARE UNIT	760,964	45,407	806,371	0	806,371	31.00
43.00	04300	NURSERY	23,868	547	24,415	0	24,415	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	388,074	476,895	864,969	-247,544	617,425	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	773	773	27,817	28,590	52.00
53.00	05300	ANESTHESIOLOGY	182,308	711	183,019	-182,308	711	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	849,303	605,502	1,454,805	0	1,454,805	54.00
60.00	06000	LABORATORY	868,598	1,475,797	2,344,395	0	2,344,395	60.00
65.00	06500	RESPIRATORY THERAPY	441,296	40,896	482,192	0	482,192	65.00
66.00	06600	PHYSICAL THERAPY	395,931	19,128	415,059	-91,522	323,537	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	91,522	91,522	67.00
68.00	06800	SPEECH PATHOLOGY	42,277	0	42,277	0	42,277	68.00
69.00	06900	ELECTROCARDIOLOGY	31,807	22,288	54,095	0	54,095	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	439,428	439,428	-4,068	435,360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,068	4,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	256,976	1,384,050	1,641,026	0	1,641,026	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,045,753	693,770	1,739,523	0	1,739,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,962,001	17,430,983	29,392,984	-191,838	29,201,146	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	191,838	191,838	194.00
200.00		TOTAL (SUM OF LINES 118-199)	11,962,001	17,430,983	29,392,984	0	29,392,984	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-15,422	1,035,793		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-174,970	240,830		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,134,601		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,611,620	3,432,484		5.00
7.00	00700	OPERATION OF PLANT	0	1,396,408		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	179,065		8.00
9.00	00900	HOUSEKEEPING	0	451,300		9.00
10.00	01000	DIETARY	0	124,017		10.00
11.00	01100	CAFETERIA	-310,288	591,452		11.00
13.00	01300	NURSING ADMINISTRATION	0	692,872		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	155,445		14.00
15.00	01500	PHARMACY	0	545,080		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,444	239,725		16.00
17.00	01700	SOCIAL SERVICE	0	143,789		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	429,852		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-691,497	2,507,880		30.00
31.00	03100	INTENSIVE CARE UNIT	0	806,371		31.00
43.00	04300	NURSERY	0	24,415		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	617,425		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,590		52.00
53.00	05300	ANESTHESIOLOGY	0	711		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,454,805		54.00
60.00	06000	LABORATORY	-31,446	2,312,949		60.00
65.00	06500	RESPIRATORY THERAPY	0	482,192		65.00
66.00	06600	PHYSICAL THERAPY	-346	323,191		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	91,522		67.00
68.00	06800	SPEECH PATHOLOGY	0	42,277		68.00
69.00	06900	ELECTROCARDIOLOGY	0	54,095		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	435,360		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,068		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,641,026		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	1,739,523		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,842,033	26,359,113		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	FOUNDATION / MOBS	0	191,838		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,842,033	26,550,951		200.00

RECLASSIFICATIONS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/28/2015 2:21 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CRNA RECLASS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	182,308	247,544	1.00
2.00		0.00	0	0	2.00
	TOTALS		182,308	247,544	
	B - LABOR & DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	27,817	0	1.00
	TOTALS		27,817	0	
	C - DIETARY RECLASS				
1.00	CAFETERIA	11.00	434,123	467,617	1.00
	TOTALS		434,123	467,617	
	D - THERAPY RECLASS				
1.00	OCCUPATIONAL THERAPY	67.00	91,522	0	1.00
	TOTALS		91,522	0	
	E - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,318	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,113	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	144,608	3.00
	TOTALS		0	189,039	
	F - OB ON CALL RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	0	116,250	1.00
	TOTALS		0	116,250	
	G - IMPLANTABLE DEVICE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,068	1.00
	TOTALS		0	4,068	
	H - RELATED PARTIES RECLASS				
1.00	FOUNDATION / MOBS	194.00	0	191,838	1.00
	TOTALS		0	191,838	
500.00	Grand Total: Increases		735,770	1,216,356	500.00

RECLASSIFICATIONS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/28/2015 2:21 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CRNA RECLASS					
1.00	ANESTHESIOLOGY	53.00	182,308	0	0	1.00
2.00	OPERATING ROOM	50.00	0	247,544	0	2.00
	TOTALS		182,308	247,544		
	B - LABOR & DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	27,817	0	0	1.00
	TOTALS		27,817	0		
	C - DIETARY RECLASS					
1.00	DIETARY	10.00	434,123	467,617	0	1.00
	TOTALS		434,123	467,617		
	D - THERAPY RECLASS					
1.00	PHYSICAL THERAPY	66.00	91,522	0	0	1.00
	TOTALS		91,522	0		
	E - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	189,039	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	189,039		
	F - OB ON CALL RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	116,250	0	1.00
	TOTALS		0	116,250		
	G - IMPLANTABLE DEVICE RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,068	0	1.00
	TOTALS		0	4,068		
	H - RELATED PARTIES RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	191,838	0	1.00
	TOTALS		0	191,838		
500.00	Grand Total: Decreases		735,770	1,216,356		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/28/2015 2:21 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	759,198	0	0	0	0	1.00
2.00	Land Improvements	689,896	74,287	0	74,287	382,411	2.00
3.00	Buildings and Fixtures	10,689,160	1,083,202	0	1,083,202	4,471,484	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,501,567	10,294	0	10,294	754,878	5.00
6.00	Movable Equipment	4,654,019	180,227	0	180,227	2,452,345	6.00
7.00	HIT designated Assets	739,352	127,800	0	127,800	0	7.00
8.00	Subtotal (sum of lines 1-7)	21,033,192	1,475,810	0	1,475,810	8,061,118	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	21,033,192	1,475,810	0	1,475,810	8,061,118	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	759,198	0	1.00
2.00	Land Improvements	381,772	0	2.00
3.00	Buildings and Fixtures	7,300,878	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,756,983	0	5.00
6.00	Movable Equipment	2,381,901	0	6.00
7.00	HIT designated Assets	867,152	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,447,884	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,447,884	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/28/2015 2:21 pm

	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	608,611	0	357,968	42,318	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	411,574	0	0	2,113	0	2.00
3.00	Total (sum of lines 1-2)	1,020,185	0	357,968	44,431	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,008,897	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	413,687	2.00
3.00	Total (sum of lines 1-2)	0	1,422,584	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/28/2015 2:21 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	12,065,983	0	12,065,983	0.835138	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,381,901	0	2,381,901	0.164862	0	2.00
3.00	Total (sum of lines 1-2)	14,447,884	0	14,447,884	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	593,189	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	236,604	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	829,793	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	357,968	84,636	0	0	1,035,793	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,226	0	0	240,830	2.00
3.00	Total (sum of lines 1-2)	357,968	88,862	0	0	1,276,623	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/28/2015 2:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-19,422	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-83,497	ADULTS & PEDIATRICS	30.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-5,709	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-639,446			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	-310,288	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,444	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-174,970	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CPR TRAINING	B	-657	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC REVENUE - ADMIN	B	-4,541	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/28/2015 2:21 pm

	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	
33.02	AHA DUES	A	-2,019	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	IHA DUES	A	-538	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING & ADVERTISING	A	-83,506	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	RENTAL OF PROVIDER SPACE - BENEFITS	B	-40,258	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	GIFT CARD USAGE	B	-9,519	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	THERAPY REVENUE	B	-346	PHYSICAL THERAPY	66.00	0	33.07
33.08	FLOWERS	A	-142	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PHYSICIAN GIFTS	A	-911	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	DONATIONS	A	-50	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	SCHOLARSHIP WINNER PAYMENT	A	-500	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	HOSPITAL ASSESSMENT FEE	A	-1,484,106	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	BOND AMORTIZATION EXPENSE ADJUSTMENT	A	24,836	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,842,033				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: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/28/2015 2:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	31,446	31,446	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	608,000	608,000	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			639,446	639,446	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	31,446		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	608,000		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		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	639,446		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,035,793	1,035,793				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	240,830		240,830			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,134,601	0	0	4,134,601		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,432,484	79,869	18,570	530,236	4,061,159	5.00
7.00	00700	OPERATION OF PLANT	1,396,408	130,802	30,412	144,309	1,701,931	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	179,065	6,968	1,620	0	187,653	8.00
9.00	00900	HOUSEKEEPING	451,300	7,710	1,793	124,635	585,438	9.00
10.00	01000	DIETARY	124,017	36,394	8,462	20,280	189,153	10.00
11.00	01100	CAFETERIA	591,452	39,977	9,295	147,462	788,186	11.00
13.00	01300	NURSING ADMINISTRATION	692,872	5,009	1,165	196,724	895,770	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	155,445	44,944	10,450	0	210,839	14.00
15.00	01500	PHARMACY	545,080	22,388	5,205	155,009	727,682	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	239,725	14,916	3,468	79,971	338,080	16.00
17.00	01700	SOCIAL SERVICE	143,789	4,002	930	48,842	197,563	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	429,852	0	0	61,926	491,778	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,507,880	167,112	38,854	819,829	3,533,675	30.00
31.00	03100	INTENSIVE CARE UNIT	806,371	37,500	8,719	258,483	1,111,073	31.00
43.00	04300	NURSERY	24,415	7,136	1,659	8,107	41,317	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	617,425	109,225	25,396	131,820	883,866	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,590	88,083	20,480	9,447	146,600	52.00
53.00	05300	ANESTHESIOLOGY	711	0	0	61,926	62,637	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,454,805	63,722	14,816	288,490	1,821,833	54.00
60.00	06000	LABORATORY	2,312,949	26,096	6,068	295,044	2,640,157	60.00
65.00	06500	RESPIRATORY THERAPY	482,192	7,164	1,666	149,899	640,921	65.00
66.00	06600	PHYSICAL THERAPY	323,191	8,885	2,066	134,489	468,631	66.00
67.00	06700	OCCUPATIONAL THERAPY	91,522	8,885	2,066	0	102,473	67.00
68.00	06800	SPEECH PATHOLOGY	42,277	8,885	2,066	14,361	67,589	68.00
69.00	06900	ELECTROCARDIOLOGY	54,095	3,820	888	10,804	69,607	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	435,360	0	0	0	435,360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,068	0	0	0	4,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,641,026	11,250	2,616	87,289	1,742,181	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,739,523	79,449	18,473	355,219	2,192,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,359,113	1,020,191	237,203	4,134,601	26,339,884	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,890	904	0	4,794	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,712	2,723	0	14,435	192.00
194.00	07950	FOUNDATION / MOBS	191,838	0	0	0	191,838	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	26,550,951	1,035,793	240,830	4,134,601	26,550,951	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,061,159					5.00
7.00	00700	OPERATION OF PLANT	307,331	2,009,262				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,886	16,968	238,507			8.00
9.00	00900	HOUSEKEEPING	105,717	18,774	0	709,929		9.00
10.00	01000	DIETARY	34,157	88,624	0	0	311,934	10.00
11.00	01100	CAFETERIA	142,329	97,347	0	12,287	0	11.00
13.00	01300	NURSING ADMINISTRATION	161,756	12,198	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	38,073	109,443	1,114	6,144	0	14.00
15.00	01500	PHARMACY	131,403	54,517	0	7,850	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,050	36,322	0	9,215	0	16.00
17.00	01700	SOCIAL SERVICE	35,676	9,745	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	88,804	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	638,102	406,940	70,752	277,146	281,636	30.00
31.00	03100	INTENSIVE CARE UNIT	200,635	91,316	18,677	74,747	30,298	31.00
43.00	04300	NURSERY	7,461	17,377	0	4,437	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	159,607	265,975	24,303	82,939	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,473	214,491	0	4,437	0	52.00
53.00	05300	ANESTHESIOLOGY	11,311	0	0	1,024	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	328,983	155,169	32,367	44,712	0	54.00
60.00	06000	LABORATORY	476,754	63,547	0	19,796	0	60.00
65.00	06500	RESPIRATORY THERAPY	115,736	17,445	0	10,239	0	65.00
66.00	06600	PHYSICAL THERAPY	84,624	21,636	34,944	6,485	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,504	21,636	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,205	21,636	0	341	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,569	9,302	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	78,616	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	735	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	314,600	27,395	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	395,947	193,468	51,350	112,292	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,023,044	1,971,271	233,507	674,091	311,934	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	866	9,472	0	7,509	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,607	28,519	5,000	28,329	0	192.00
194.00	07950	FOUNDATION / MOBS	34,642	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,061,159	2,009,262	238,507	709,929	311,934	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,040,149					11.00
13.00	01300	NURSING ADMINISTRATION	48,150	1,117,874				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	365,613			14.00
15.00	01500	PHARMACY	39,231	0	0	960,683		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,672	0	0	0	482,339	16.00
17.00	01700	SOCIAL SERVICE	14,283	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,237	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	295,072	644,487	0	0	87,118	30.00
31.00	03100	INTENSIVE CARE UNIT	69,605	152,029	0	0	16,999	31.00
43.00	04300	NURSERY	6,362	13,895	0	0	1,594	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,360	81,600	0	0	5,843	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,133	0	0	0	3,187	52.00
53.00	05300	ANESTHESIOLOGY	6,237	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,177	0	0	0	20,186	54.00
60.00	06000	LABORATORY	118,566	0	0	0	37,185	60.00
65.00	06500	RESPIRATORY THERAPY	47,214	0	0	0	1,062	65.00
66.00	06600	PHYSICAL THERAPY	33,618	0	0	0	5,843	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,859	0	0	0	2,656	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,594	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	5,312	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	362,228	0	1,594	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,385	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,963	0	0	960,683	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	103,410	225,863	0	0	292,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,040,149	1,117,874	365,613	960,683	482,339	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,040,149	1,117,874	365,613	960,683	482,339	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	257,267					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	586,819				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	164,651	0	6,399,579	0	6,399,579	30.00
31.00	03100	INTENSIVE CARE UNIT	65,174	0	1,830,553	0	1,830,553	31.00
43.00	04300	NURSERY	3,430	0	95,873	0	95,873	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,541,493	0	1,541,493	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	451,321	0	451,321	52.00
53.00	05300	ANESTHESIOLOGY	0	586,819	668,028	0	668,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,498,427	0	2,498,427	54.00
60.00	06000	LABORATORY	0	0	3,356,005	0	3,356,005	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	832,617	0	832,617	65.00
66.00	06600	PHYSICAL THERAPY	0	0	655,781	0	655,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	153,128	0	153,128	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	103,365	0	103,365	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	96,790	0	96,790	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	877,798	0	877,798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,188	0	8,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,062,822	0	3,062,822	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	24,012	0	3,591,172	0	3,591,172	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	257,267	586,819	26,222,940	0	26,222,940	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	22,641	0	22,641	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	78,890	0	78,890	192.00
194.00	07950	FOUNDATION / MOBS	0	0	226,480	0	226,480	194.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	257,267	586,819	26,550,951	0	26,550,951	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	79,869	18,570	98,439	0	5.00
7.00	00700	OPERATION OF PLANT	0	130,802	30,412	161,214	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,968	1,620	8,588	0	8.00
9.00	00900	HOUSEKEEPING	0	7,710	1,793	9,503	0	9.00
10.00	01000	DIETARY	0	36,394	8,462	44,856	0	10.00
11.00	01100	CAFETERIA	0	39,977	9,295	49,272	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,009	1,165	6,174	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	44,944	10,450	55,394	0	14.00
15.00	01500	PHARMACY	0	22,388	5,205	27,593	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,916	3,468	18,384	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,002	930	4,932	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	167,112	38,854	205,966	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	37,500	8,719	46,219	0	31.00
43.00	04300	NURSERY	0	7,136	1,659	8,795	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	109,225	25,396	134,621	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	88,083	20,480	108,563	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	63,722	14,816	78,538	0	54.00
60.00	06000	LABORATORY	0	26,096	6,068	32,164	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,164	1,666	8,830	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,885	2,066	10,951	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,885	2,066	10,951	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,885	2,066	10,951	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,820	888	4,708	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,250	2,616	13,866	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	79,449	18,473	97,922	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,020,191	237,203	1,257,394	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,890	904	4,794	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,712	2,723	14,435	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,035,793	240,830	1,276,623	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	98,439					5.00
7.00	00700	OPERATION OF PLANT	7,449	168,663				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	821	1,424	10,833			8.00
9.00	00900	HOUSEKEEPING	2,562	1,576	0	13,641		9.00
10.00	01000	DIETARY	828	7,439	0	0	53,123	10.00
11.00	01100	CAFETERIA	3,450	8,172	0	236	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,921	1,024	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	923	9,187	51	118	0	14.00
15.00	01500	PHARMACY	3,185	4,576	0	151	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,480	3,049	0	177	0	16.00
17.00	01700	SOCIAL SERVICE	865	818	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,153	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,466	34,161	3,214	5,325	47,963	30.00
31.00	03100	INTENSIVE CARE UNIT	4,863	7,665	848	1,436	5,160	31.00
43.00	04300	NURSERY	181	1,459	0	85	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,869	22,327	1,104	1,594	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	642	18,005	0	85	0	52.00
53.00	05300	ANESTHESIOLOGY	274	0	0	20	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,974	13,025	1,470	859	0	54.00
60.00	06000	LABORATORY	11,556	5,334	0	380	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,805	1,464	0	197	0	65.00
66.00	06600	PHYSICAL THERAPY	2,051	1,816	1,587	125	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	449	1,816	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	296	1,816	0	7	0	68.00
69.00	06900	ELECTROCARDIOLOGY	305	781	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,906	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,626	2,300	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,597	16,240	2,332	2,158	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,515	165,474	10,606	12,953	53,123	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21	795	0	144	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	63	2,394	227	544	0	192.00
194.00	07950	FOUNDATION / MOBS	840	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	98,439	168,663	10,833	13,641	53,123	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	61,130					11.00
13.00	01300	NURSING ADMINISTRATION	2,830	13,949				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	65,673			14.00
15.00	01500	PHARMACY	2,306	0	0	37,811		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,214	0	0	0	25,304	16.00
17.00	01700	SOCIAL SERVICE	839	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	367	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,339	8,043	0	0	4,570	30.00
31.00	03100	INTENSIVE CARE UNIT	4,091	1,897	0	0	892	31.00
43.00	04300	NURSERY	374	173	0	0	84	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,196	1,018	0	0	307	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,299	0	0	0	167	52.00
53.00	05300	ANESTHESIOLOGY	367	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,594	0	0	0	1,059	54.00
60.00	06000	LABORATORY	6,968	0	0	0	1,951	60.00
65.00	06500	RESPIRATORY THERAPY	2,775	0	0	0	56	65.00
66.00	06600	PHYSICAL THERAPY	1,976	0	0	0	307	66.00
67.00	06700	OCCUPATIONAL THERAPY	462	0	0	0	139	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	84	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	65,065	0	84	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	608	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,056	0	0	37,811	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,077	2,818	0	0	15,325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,130	13,949	65,673	37,811	25,304	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	61,130	13,949	65,673	37,811	25,304	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	7,454					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	2,520				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,771		346,818	0	346,818	30.00
31.00	03100	INTENSIVE CARE UNIT	1,888		74,959	0	74,959	31.00
43.00	04300	NURSERY	99		11,250	0	11,250	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		167,036	0	167,036	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		130,761	0	130,761	52.00
53.00	05300	ANESTHESIOLOGY	0		661	0	661	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		108,519	0	108,519	54.00
60.00	06000	LABORATORY	0		58,353	0	58,353	60.00
65.00	06500	RESPIRATORY THERAPY	0		16,127	0	16,127	65.00
66.00	06600	PHYSICAL THERAPY	0		18,813	0	18,813	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		13,817	0	13,817	67.00
68.00	06800	SPEECH PATHOLOGY	0		13,154	0	13,154	68.00
69.00	06900	ELECTROCARDIOLOGY	0		6,073	0	6,073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		67,055	0	67,055	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		626	0	626	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		62,659	0	62,659	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	696		153,165	0	153,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,454	0	1,249,846	0	1,249,846	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		5,754	0	5,754	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		17,663	0	17,663	192.00
194.00	07950	FOUNDATION / MOBS	0		840	0	840	194.00
200.00		Cross Foot Adjustments		2,520	2,520	0	2,520	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,454	2,520	1,276,623	0	1,276,623	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	74,025					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		74,025				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	12,172,121			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,708	5,708	1,560,996	-4,061,159	22,489,792	5.00
7.00	00700	OPERATION OF PLANT	9,348	9,348	424,842	0	1,701,931	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	498	498	0	0	187,653	8.00
9.00	00900	HOUSEKEEPING	551	551	366,921	0	585,438	9.00
10.00	01000	DIETARY	2,601	2,601	59,705	0	189,153	10.00
11.00	01100	CAFETERIA	2,857	2,857	434,123	0	788,186	11.00
13.00	01300	NURSING ADMINISTRATION	358	358	579,149	0	895,770	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,212	3,212	0	0	210,839	14.00
15.00	01500	PHARMACY	1,600	1,600	456,342	0	727,682	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	235,433	0	338,080	16.00
17.00	01700	SOCIAL SERVICE	286	286	143,789	0	197,563	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	182,308	0	491,778	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,943	11,943	2,413,546	0	3,533,675	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	2,680	760,964	0	1,111,073	31.00
43.00	04300	NURSERY	510	510	23,868	0	41,317	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,806	7,806	388,074	0	883,866	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,295	6,295	27,812	0	146,600	52.00
53.00	05300	ANESTHESIOLOGY	0	0	182,308	0	62,637	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	4,554	849,303	0	1,821,833	54.00
60.00	06000	LABORATORY	1,865	1,865	868,598	0	2,640,157	60.00
65.00	06500	RESPIRATORY THERAPY	512	512	441,296	0	640,921	65.00
66.00	06600	PHYSICAL THERAPY	635	635	395,931	0	468,631	66.00
67.00	06700	OCCUPATIONAL THERAPY	635	635	0	0	102,473	67.00
68.00	06800	SPEECH PATHOLOGY	635	635	42,277	0	67,589	68.00
69.00	06900	ELECTROCARDIOLOGY	273	273	31,807	0	69,607	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	435,360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	804	804	256,976	0	1,742,181	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,678	5,678	1,045,753	0	2,192,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,910	72,910	12,172,121	-4,061,159	22,278,725	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	278	0	0	4,794	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	837	837	0	0	14,435	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	191,838	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,035,793	240,830	4,134,601		4,061,159	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.992476	3.253360	0.339678		0.180578	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		98,439	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.004377	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PIECES OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	58,969					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	498	17,125				8.00
9.00	00900	HOUSEKEEPING	551	0	2,080			9.00
10.00	01000	DIETARY	2,601	0	0	8,988		10.00
11.00	01100	CAFETERIA	2,857	0	36	0	16,677	11.00
13.00	01300	NURSING ADMINISTRATION	358	0	0	0	772	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,212	80	18	0	0	14.00
15.00	01500	PHARMACY	1,600	0	23	0	629	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066	0	27	0	604	16.00
17.00	01700	SOCIAL SERVICE	286	0	0	0	229	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,943	5,080	812	8,115	4,731	30.00
31.00	03100	INTENSIVE CARE UNIT	2,680	1,341	219	873	1,116	31.00
43.00	04300	NURSERY	510	0	13	0	102	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,806	1,745	243	0	599	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,295	0	13	0	900	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,554	2,324	131	0	1,526	54.00
60.00	06000	LABORATORY	1,865	0	58	0	1,901	60.00
65.00	06500	RESPIRATORY THERAPY	512	0	30	0	757	65.00
66.00	06600	PHYSICAL THERAPY	635	2,509	19	0	539	66.00
67.00	06700	OCCUPATIONAL THERAPY	635	0	0	0	126	67.00
68.00	06800	SPEECH PATHOLOGY	635	0	1	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	273	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	804	0	0	0	288	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,678	3,687	329	0	1,658	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	57,854	16,766	1,975	8,988	16,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	0	22	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	837	359	83	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,009,262	238,507	709,929	311,934	1,040,149	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.073191	13.927416	341.312019	34.705607	62.370270	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	168,663	10,833	13,641	53,123	61,130	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.860198	0.632584	6.558173	5.910436	3.665527	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	8,206					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	439,428				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	908		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	75	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,731	0	0	164	48	30.00
31.00	03100	INTENSIVE CARE UNIT	1,116	0	0	32	19	31.00
43.00	04300	NURSERY	102	0	0	3	1	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	599	0	0	11	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	38	0	54.00
60.00	06000	LABORATORY	0	0	0	70	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	435,360	0	3	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,068	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,658	0	0	550	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,206	439,428	100	908	75	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION / MOBS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,117,874	365,613	960,683	482,339	257,267	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	136.226420	0.832020	9,606.830000	531.210352	3,430.226667	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,949	65,673	37,811	25,304	7,454	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.699854	0.149451	378.110000	27.867841	99.386667	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/28/2015 2:21 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	FOUNDATION / MOBS	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	586,819	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5,868.190000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,520	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	25.200000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,399,579		6,399,579	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,830,553		1,830,553	0	0	31.00
43.00	04300	NURSERY	95,873		95,873	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,541,493		1,541,493	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	451,321		451,321	0	0	52.00
53.00	05300	ANESTHESIOLOGY	668,028		668,028	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,498,427		2,498,427	0	0	54.00
60.00	06000	LABORATORY	3,356,005		3,356,005	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	832,617	0	832,617	0	0	65.00
66.00	06600	PHYSICAL THERAPY	655,781	0	655,781	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,128	0	153,128	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	103,365	0	103,365	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	96,790		96,790	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	877,798		877,798	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,188		8,188	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,062,822		3,062,822	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,591,172		3,591,172	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,925,023		1,925,023		0	92.00
200.00		Subtotal (see instructions)	28,147,963	0	28,147,963	0	0	200.00
201.00		Less Observation Beds	1,925,023		1,925,023		0	201.00
202.00		Total (see instructions)	26,222,940	0	26,222,940	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,536,726		2,536,726			30.00
31.00	03100	INTENSIVE CARE UNIT	806,704		806,704			31.00
43.00	04300	NURSERY	193,662		193,662			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	597,366	2,418,625	3,015,991	0.511107	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,480	105,245	282,725	1.596325	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	237,483	535,390	772,873	0.864344	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	618,487	11,966,372	12,584,859	0.198526	0.000000	54.00
60.00	06000	LABORATORY	941,015	10,291,759	11,232,774	0.298769	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	566,383	449,579	1,015,962	0.819536	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	142,785	1,485,157	1,627,942	0.402828	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,954	399,733	461,687	0.331671	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,818	164,903	181,721	0.568812	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	317,508	1,703,287	2,020,795	0.047897	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,015,509	1,082,842	2,098,351	0.418328	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	68,071	68,071	0.120286	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,999,562	6,566,820	8,566,382	0.357540	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	331,710	13,217,304	13,549,014	0.265050	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,690,758	1,690,758	1.138556	0.000000	92.00
200.00		Subtotal (see instructions)	10,561,152	52,145,845	62,706,997			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,561,152	52,145,845	62,706,997			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,399,579		6,399,579	0	6,399,579	30.00
31.00	03100	INTENSIVE CARE UNIT	1,830,553		1,830,553	0	1,830,553	31.00
43.00	04300	NURSERY	95,873		95,873	0	95,873	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,541,493		1,541,493	0	1,541,493	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	451,321		451,321	0	451,321	52.00
53.00	05300	ANESTHESIOLOGY	668,028		668,028	0	668,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,498,427		2,498,427	0	2,498,427	54.00
60.00	06000	LABORATORY	3,356,005		3,356,005	0	3,356,005	60.00
65.00	06500	RESPIRATORY THERAPY	832,617	0	832,617	0	832,617	65.00
66.00	06600	PHYSICAL THERAPY	655,781	0	655,781	0	655,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,128	0	153,128	0	153,128	67.00
68.00	06800	SPEECH PATHOLOGY	103,365	0	103,365	0	103,365	68.00
69.00	06900	ELECTROCARDIOLOGY	96,790		96,790	0	96,790	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	877,798		877,798	0	877,798	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,188		8,188	0	8,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,062,822		3,062,822	0	3,062,822	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,591,172		3,591,172	0	3,591,172	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,925,023		1,925,023		1,925,023	92.00
200.00		Subtotal (see instructions)	28,147,963	0	28,147,963	0	28,147,963	200.00
201.00		Less Observation Beds	1,925,023		1,925,023		1,925,023	201.00
202.00		Total (see instructions)	26,222,940	0	26,222,940	0	26,222,940	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,536,726		2,536,726			30.00
31.00	03100	INTENSIVE CARE UNIT	806,704		806,704			31.00
43.00	04300	NURSERY	193,662		193,662			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	597,366	2,418,625	3,015,991	0.511107	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,480	105,245	282,725	1.596325	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	237,483	535,390	772,873	0.864344	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	618,487	11,966,372	12,584,859	0.198526	0.000000	54.00
60.00	06000	LABORATORY	941,015	10,291,759	11,232,774	0.298769	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	566,383	449,579	1,015,962	0.819536	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	142,785	1,485,157	1,627,942	0.402828	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,954	399,733	461,687	0.331671	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,818	164,903	181,721	0.568812	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	317,508	1,703,287	2,020,795	0.047897	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,015,509	1,082,842	2,098,351	0.418328	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	68,071	68,071	0.120286	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,999,562	6,566,820	8,566,382	0.357540	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	331,710	13,217,304	13,549,014	0.265050	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,690,758	1,690,758	1.138556	0.000000	92.00
200.00		Subtotal (see instructions)	10,561,152	52,145,845	62,706,997			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,561,152	52,145,845	62,706,997			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/28/2015 2:21 pm

Title XIX | Hospital | Cost

		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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	167,036	3,015,991	0.055383	221,934	12,291	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	130,761	282,725	0.462502	0	0	52.00
53.00	05300	ANESTHESIOLOGY	661	772,873	0.000855	61,567	53	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,519	12,584,859	0.008623	450,751	3,887	54.00
60.00	06000	LABORATORY	58,353	11,232,774	0.005195	616,004	3,200	60.00
65.00	06500	RESPIRATORY THERAPY	16,127	1,015,962	0.015874	261,350	4,149	65.00
66.00	06600	PHYSICAL THERAPY	18,813	1,627,942	0.011556	68,893	796	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,817	461,687	0.029927	19,726	590	67.00
68.00	06800	SPEECH PATHOLOGY	13,154	181,721	0.072386	9,348	677	68.00
69.00	06900	ELECTROCARDIOLOGY	6,073	2,020,795	0.003005	277,580	834	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,055	2,098,351	0.031956	70,543	2,254	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	626	68,071	0.009196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,659	8,566,382	0.007315	1,700,586	12,440	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	153,165	13,549,014	0.011305	13,826	156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	116,071	1,690,758	0.068650	0	0	92.00
200.00		Total (lines 50-199)	932,890	59,169,905		3,772,108	41,327	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	586,819	0	0	0	586,819	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	586,819	0	0	0	586,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,015,991	0.000000	0.000000	221,934	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	282,725	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	772,873	0.759270	0.000000	61,567	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,584,859	0.000000	0.000000	450,751	54.00
60.00	06000	LABORATORY	0	11,232,774	0.000000	0.000000	616,004	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,015,962	0.000000	0.000000	261,350	65.00
66.00	06600	PHYSICAL THERAPY	0	1,627,942	0.000000	0.000000	68,893	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	461,687	0.000000	0.000000	19,726	67.00
68.00	06800	SPEECH PATHOLOGY	0	181,721	0.000000	0.000000	9,348	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,020,795	0.000000	0.000000	277,580	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,098,351	0.000000	0.000000	70,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	68,071	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,566,382	0.000000	0.000000	1,700,586	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	13,549,014	0.000000	0.000000	13,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,690,758	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	59,169,905			3,772,108	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	46,746	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	46,746	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.511107	0	990,772	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.596325	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.864344	0	179,309	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198526	0	4,518,575	0	0	54.00
60.00	06000	LABORATORY	0.298769	0	4,490,624	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.819536	0	122,213	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.402828	0	556,987	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331671	0	113,516	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.568812	0	28,561	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047897	0	1,040,256	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.418328	0	470,898	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.120286	0	46,079	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357540	0	3,502,804	632	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.265050	0	4,286,253	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.138556	0	833,492	0	0	92.00
200.00		Subtotal (see instructions)		0	21,180,339	632	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	21,180,339	632	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	506,391	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	154,985	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	897,055	0		54.00
60.00	06000	LABORATORY	1,341,659	0		60.00
65.00	06500	RESPIRATORY THERAPY	100,158	0		65.00
66.00	06600	PHYSICAL THERAPY	224,370	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	37,650	0		67.00
68.00	06800	SPEECH PATHOLOGY	16,246	0		68.00
69.00	06900	ELECTROCARDIOLOGY	49,825	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	196,990	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,543	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,252,393	226		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	1,136,071	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	948,977	0		92.00
200.00		Subtotal (see instructions)	6,868,313	226		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,868,313	226		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317 | Component CCN: 15Z317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.511107	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.596325	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.864344	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198526	0	0	0	0	54.00
60.00	06000	LABORATORY	0.298769	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.819536	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.402828	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331671	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.568812	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047897	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.418328	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.120286	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357540	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.265050	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.138556	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	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	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317 | Component CCN: 15Z317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.511107	0	150,400	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.596325	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.864344	0	33,293	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198526	0	744,118	0	0	54.00
60.00	06000	LABORATORY	0.298769	0	639,984	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.819536	0	34,501	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.402828	0	92,353	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331671	0	24,857	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.568812	0	10,254	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047897	0	112,136	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.418328	0	71,568	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.120286	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357540	0	414,570	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.265050	0	821,906	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.138556	0	104,223	0	0	92.00
200.00		Subtotal (see instructions)		0	3,254,163	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	3,254,163	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/28/2015 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	76,870	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	28,777	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147,727	0		54.00
60.00	06000	LABORATORY	191,207	0		60.00
65.00	06500	RESPIRATORY THERAPY	28,275	0		65.00
66.00	06600	PHYSICAL THERAPY	37,202	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	8,244	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,833	0		68.00
69.00	06900	ELECTROCARDIOLOGY	5,371	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,939	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	148,225	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	217,846	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	118,664	0		92.00
200.00		Subtotal (see instructions)	1,044,180	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,044,180	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | 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)	3,877	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,478	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,314	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	391	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	8	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,348	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)	391	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	130.15	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)	6,399,579	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)	1,041	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)	647,677	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,751,902	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)	5,751,902	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,653.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,229,322	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)	2,229,322	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,830,553	447	4,095.20	318	1,302,274	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,348,472	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,880,068	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)	646,636	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)	646,636	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,164	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,653.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,925,023	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	346,818	5,751,902	0.060296	1,925,023	116,071	90.00
91.00	Nursing School cost	0	5,751,902	0.000000	1,925,023	0	91.00
92.00	Allied health cost	0	5,751,902	0.000000	1,925,023	0	92.00
93.00	All other Medical Education	0	5,751,902	0.000000	1,925,023	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:21 pm

	Cost Center Description	Title XIX	Hospital	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,877	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,478	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,314	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			8	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)			37	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)			161	15.00
16.00	Nursery days (title V or XIX only)			42	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				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				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)			6,399,579	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)			6,399,579	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)			6,399,579	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,840.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			68,081	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)			68,081	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	95,873	161	595.48	42	25,010	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,830,553	447	4,095.20	17	69,618	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	140,364	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	303,073	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)	1,164	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,840.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,141,783	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/28/2015 2:21 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	346,818	6,399,579	0.054194	2,141,783	116,072	90.00
91.00	Nursing School cost	0	6,399,579	0.000000	2,141,783	0	91.00
92.00	Allied health cost	0	6,399,579	0.000000	2,141,783	0	92.00
93.00	All other Medical Education	0	6,399,579	0.000000	2,141,783	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,665,586		30.00
31.00	03100	INTENSIVE CARE UNIT		646,176		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.511107	221,934	113,432	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.596325	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.864344	61,567	53,215	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198526	450,751	89,486	54.00
60.00	06000	LABORATORY	0.298769	616,004	184,043	60.00
65.00	06500	RESPIRATORY THERAPY	0.819536	261,350	214,186	65.00
66.00	06600	PHYSICAL THERAPY	0.402828	68,893	27,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331671	19,726	6,543	67.00
68.00	06800	SPEECH PATHOLOGY	0.568812	9,348	5,317	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047897	277,580	13,295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.418328	70,543	29,510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.120286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357540	1,700,586	608,028	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.265050	13,826	3,665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.138556	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,772,108	1,348,472	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)		3,772,108		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151317 | Component CCN: 15Z317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.511107	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.596325	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.864344	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198526	23,726	4,710	54.00
60.00	06000	LABORATORY	0.298769	40,147	11,995	60.00
65.00	06500	RESPIRATORY THERAPY	0.819536	51,677	42,351	65.00
66.00	06600	PHYSICAL THERAPY	0.402828	58,077	23,395	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331671	36,854	12,223	67.00
68.00	06800	SPEECH PATHOLOGY	0.568812	5,808	3,304	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047897	28,812	1,380	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.418328	87,392	36,559	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.120286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357540	160,647	57,438	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.265050	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.138556	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		493,140	193,355	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)		493,140		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/28/2015 2:21 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		123,108		30.00
31.00	03100	INTENSIVE CARE UNIT		38,924		31.00
43.00	04300	NURSERY		9,344		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.511107	28,823	14,732	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.596325	5,901	9,420	52.00
53.00	05300	ANESTHESIOLOGY	0.864344	11,459	9,905	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198526	29,842	5,924	54.00
60.00	06000	LABORATORY	0.298769	45,404	13,565	60.00
65.00	06500	RESPIRATORY THERAPY	0.819536	29,990	24,578	65.00
66.00	06600	PHYSICAL THERAPY	0.402828	6,889	2,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331671	2,989	991	67.00
68.00	06800	SPEECH PATHOLOGY	0.568812	811	461	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047897	10,495	503	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.418328	48,999	20,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.120286	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357540	91,654	32,770	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.265050	16,005	4,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.138556	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		329,261	140,364	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)		329,261		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151317	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 2:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,868,539	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,868,539	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 chargebasis 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)	6,937,224	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	38,586	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,358,650	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)	3,539,988	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)	3,539,988	30.00
31.00	Primary payer payments	570	31.00
32.00	Subtotal (line 30 minus line 31)	3,539,418	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)	108,225	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	82,251	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,205	36.00
37.00	Subtotal (see instructions)	3,621,669	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,621,669	40.00
40.01	Sequestration adjustment (see instructions)	72,433	40.01
41.00	Interim payments	3,727,387	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-178,151	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Hospital | Cost

		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		4,374,961		3,727,387	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,374,961		3,727,387	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		83,619		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		178,151	6.02
7.00	Total Medicare program liability (see instructions)		4,458,580		3,549,236	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/28/2015 2:21 pm

Component CCN: 15Z317 | Title XVIII | Swing Beds - SNF | Cost

		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		791,344		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		791,344		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		31,291		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		822,635		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151317	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/28/2015 2:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	751	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,666	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,761	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	62,706,997	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	736,303	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	323,026	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	261,845	8.00
9.00	Sequestration adjustment amount (see instructions)	5,237	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	256,608	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	256,608	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151317 | Component CCN: 15Z317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-2 | Date/Time Prepared: 5/28/2015 2:21 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	653,102	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	195,289	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	391	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	848,391	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	848,391	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	848,391	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,968	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	839,423	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	839,423	0	19.00
19.01	Sequestration adjustment (see instructions)	16,788	0	19.01
20.00	Interim payments	791,344	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	31,291	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151317	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/28/2015 2:21 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,880,068	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	4,880,068	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,928,869	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,928,869	19.00
20.00	Deductibles (exclude professional component)	426,784	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,502,085	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	4,502,085	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	62,482	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	47,486	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5,506	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,549,571	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	4,549,571	30.00
30.01	Sequestration adjustment (see instructions)	90,991	30.01
31.00	Interim payments	4,374,961	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	83,619	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151317	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2015 2:21 pm
	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	303,073		1.00
2.00	Medical and other services		1,044,180	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	303,073	1,044,180	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	303,073	1,044,180	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	329,261	3,254,163	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)	329,261	3,254,163	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)	329,261	3,254,163	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	26,188	2,209,983	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)	303,073	1,044,180	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		24.00
25.00	Capital exception payments (see instructions)	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)	303,073	1,044,180	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)	303,073	1,044,180	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		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	303,073	1,044,180	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	303,073	1,044,180	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	303,073	1,044,180	40.00
41.00	Interim payments	303,073	1,044,180	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/28/2015 2:21 pm

		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	106,651	0	0	0	1.00
2.00	Temporary investments	1,147,847	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,288,200	0	0	0	4.00
5.00	Other receivable	-805,315	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	359,915	0	0	0	7.00
8.00	Prepaid expenses	2,361,999	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)	7,459,297	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	759,198	0	0	0	12.00
13.00	Land improvements	381,772	0	0	0	13.00
14.00	Accumulated depreciation	-80,999	0	0	0	14.00
15.00	Buildings	7,300,878	0	0	0	15.00
16.00	Accumulated depreciation	-2,176,150	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	3,624,135	0	0	0	19.00
20.00	Accumulated depreciation	-466,449	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,381,901	0	0	0	23.00
24.00	Accumulated depreciation	-987,795	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)	10,736,491	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	881,563	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	52,664	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	934,227	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	19,130,015	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,277,004	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,787,737	0	0	0	38.00
39.00	Payroll taxes payable	116,784	0	0	0	39.00
40.00	Notes and loans payable (short term)	295,029	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,476,554	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,968,540	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	8,968,540	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	12,445,094	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	6,684,921				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	6,684,921	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	19,130,015	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/28/2015 2:21 pm

		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		7,556,587		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-871,666				2.00
3.00	Total (sum of line 1 and line 2)		6,684,921		0		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)		6,684,921		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)		6,684,921		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: 151317 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/28/2015 2:21 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,551,443		2,551,443	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)	2,551,443		2,551,443	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	806,704		806,704	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	806,704		806,704	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,358,147		3,358,147	17.00
18.00	Ancillary services	7,019,546	52,329,304	59,348,850	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,377,693	52,329,304	62,706,997	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,392,984		29.00
30.00	EXPENSES NOT INCLUDED ON WORKSHEET A	5,698,145			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)		5,698,145		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)		35,091,129		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151317	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/28/2015 2:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,706,997	1.00
2.00	Less contractual allowances and discounts on patients' accounts	30,663,158	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,043,839	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,091,129	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,047,290	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER: GRANTS, PURCHASING DISCOUNTS,	2,175,624	24.00
25.00	Total other income (sum of lines 6-24)	2,175,624	25.00
26.00	Total (line 5 plus line 25)	-871,666	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)	-871,666	29.00