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: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/21/2015 1:31 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/21/2015 Time: 1:31 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 JOHNSON MEMORIAL HOSPITAL (150001) 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	34,467	-76,016	12,739	152,184	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	26,707	-3		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	61,174	-76,019	12,739	152,184	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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2015 1:29 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1125 WEST JEFFERSON STREET	PO Box:			1.00
2.00	City: FRANKLIN	State: IN	Zip Code: 46131-	County: JOHNSON	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	JOHNSON MEMORIAL HOSPITAL	150001	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	TODD AIKENS REHAB CENTER	15T001	99915	5	01/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	JOHNSON MEMORIAL HOME HEALTH	157510	99915		07/01/1997	N	P	N	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: 1.00	To: 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.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	389	93	0	2	830	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.	175	21	0	0	17		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2015 1:29 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)	Y	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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 1:29 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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 1:29 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)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			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)	N		0	76.00

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

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		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	373,583	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)	0	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)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 1:29 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)		Y	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2015 1:29 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)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/30/2015	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	03/27/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2015 1:29 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					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BOB	BRANDENBURG			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	BBRANDENBURG@BKD.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2015 1:29 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)	03/27/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		PARTNER		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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2015 1:29 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	80	29,200	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		80	29,200	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	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)		86	31,390	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	15	5,475		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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)		101				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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2015 1:29 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)	3,283	303	6,095			1.00
2.00	HMO and other (see instructions)	956	840				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	68	38				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,283	303	6,095			7.00
8.00	INTENSIVE CARE UNIT	267	50	1,026			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		35	707			13.00
14.00	Total (see instructions)	3,550	388	7,828	0.00	529.59	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	702	175	1,447	0.00	11.64	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	2,954	120	5,936	0.00	10.78	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	552.01	27.00
28.00	Observation Bed Days		10	970			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	86	147			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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2015 1:29 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	894	0	2,186	1.00
2.00	HMO and other (see instructions)			172	71		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	894	0	2,186	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	60	11	117	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2015 1:29 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	33,598,085	0	33,598,085	1,148,174.00	29.26	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		10,462,777	-125,850	10,336,927	230,889.00	44.77	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,073,077	0	1,073,077	12,931.00	82.98	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		127,012	0	127,012	1,689.00	75.20	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,048,920	0	6,048,920			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,522,568	0	1,522,568			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,282,265	125,850	3,408,115	152,328.00	22.37	26.00
27.00	Administrative & General	5.00	1,871,323	0	1,871,323	60,862.00	30.75	27.00
28.00	Administrative & General under contract (see inst.)		187,812	0	187,812	1,084.00	173.26	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	643,881	0	643,881	30,112.00	21.38	30.00
31.00	Laundry & Linen Service	8.00	113,414	0	113,414	8,910.00	12.73	31.00
32.00	Housekeeping	9.00	627,961	0	627,961	52,628.00	11.93	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	742,998	-413,654	329,344	20,512.00	16.06	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	413,654	413,654	26,853.00	15.40	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,234,543	0	1,234,543	22,158.00	55.72	38.00
39.00	Central Services and Supply	14.00	78,144	0	78,144	4,322.00	18.08	39.00
40.00	Pharmacy	15.00	463,358	0	463,358	13,087.00	35.41	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2015 1:29 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	509,664	0	509,664	27,770.00	18.35	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/21/2015 1:29 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		33,785,897	0	33,785,897	1,149,258.00	29.40	1.00
2.00	Excluded area salaries (see instructions)		10,462,777	-125,850	10,336,927	230,889.00	44.77	2.00
3.00	Subtotal salaries (line 1 minus line 2)		23,323,120	125,850	23,448,970	918,369.00	25.53	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,200,089	0	1,200,089	14,620.00	82.09	4.00
5.00	Subtotal wage-related costs (see inst.)		6,048,920	0	6,048,920	0.00	25.80	5.00
6.00	Total (sum of lines 3 thru 5)		30,572,129	125,850	30,697,979	932,989.00	32.90	6.00
7.00	Total overhead cost (see instructions)		9,755,363	125,850	9,881,213	420,626.00	23.49	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/21/2015 1:29 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	739,919	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	326,501	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,837,011	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	23,305	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	67,799	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	183,373	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,818,737	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	30,295	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	22,082	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,049,022	24.00
	Part B - Other than Core Related Cost		
25.00	EXCLUDED BENEFITS	1,522,466	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 5/21/2015 1:29 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 150001 | Component CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-4 | Date/Time Prepared: 5/21/2015 1:29 pm

Home Health Agency I | PPS

		1.00	
0.00	County	JOHNSON	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,845	18	0	1,863	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	147.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.06	0.00	1.06	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		2.09	0.00	2.09	5.00
6.00	Direct Nursing Service		4.70	0.00	4.70	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		1.25	0.00	1.25	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		1.08	0.00	1.08	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.01	0.00	0.01	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.92	0.00	0.92	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		18020			20.00
20.01			26900			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,382	0	14	0	1,396	21.00
22.00	Skilled Nursing Visit Charges	284,884	0	2,304	0	287,188	22.00
23.00	Physical Therapy Visits	900	0	1	0	901	23.00
24.00	Physical Therapy Visit Charges	217,769	0	250	0	218,019	24.00
25.00	Occupational Therapy Visits	510	0	1	0	511	25.00
26.00	Occupational Therapy Visit Charges	125,001	0	250	0	125,251	26.00
27.00	Speech Pathology Visits	7	0	0	0	7	27.00
28.00	Speech Pathology Visit Charges	1,750	0	0	0	1,750	28.00
29.00	Medical Social Service Visits	5	0	0	0	5	29.00
30.00	Medical Social Service Visit Charges	1,350	0	0	0	1,350	30.00
31.00	Home Health Aide Visits	134	0	0	0	134	31.00
32.00	Home Health Aide Visit Charges	13,103	0	0	0	13,103	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,938	0	16	0	2,954	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	643,857	0	2,804	0	646,661	35.00
36.00	Total Number of Episodes (standard/non outlier)	166		4	0	170	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	2,458	0	0	0	2,458	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/21/2015 1:29 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)	0.325418	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,166,867	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?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	16,072,679	6.00
7.00	Medicaid cost (line 1 times line 6)	5,230,339	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	7,078	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	8,502,598	1,223,364	9,725,962	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,766,898	398,105	3,165,003	21.00
22.00	Partial payment by patients approved for charity care	265,987	249,232	515,219	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,500,911	148,873	2,649,784	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?		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)	6,629,615	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	131,399	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	6,498,216	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,114,636	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,764,420	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,764,420	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/21/2015 1:29 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		1,706,743	1,706,743	0	1,706,743	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER		86,509	86,509	0	86,509	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,718,329	2,718,329	0	2,718,329	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	661,951	7,622,771	8,284,722	145,487	8,430,209	4.00
4.01	00401	COMMUNICATIONS	190,811	274,746	465,557	0	465,557	4.01
4.02	00402	DATA PROCESSING	718,487	671,933	1,390,420	0	1,390,420	4.02
4.03	00403	MATERIALS MANAGEMENT	266,743	45,910	312,653	0	312,653	4.03
4.04	00404	ADMITTING	584,236	25,136	609,372	0	609,372	4.04
4.05	00405	PATIENT ACCOUNTING	860,037	544,390	1,404,427	0	1,404,427	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	1,871,323	7,691,474	9,562,797	0	9,562,797	5.00
7.00	00700	OPERATION OF PLANT	643,881	2,246,895	2,890,776	0	2,890,776	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	113,414	75,969	189,383	0	189,383	8.00
9.00	00900	HOUSEKEEPING	627,961	117,020	744,981	0	744,981	9.00
10.00	01000	DIETARY	742,998	302,973	1,045,971	-582,328	463,643	10.00
11.00	01100	CAFETERIA	0	0	0	582,328	582,328	11.00
13.00	01300	NURSING ADMINISTRATION	1,234,543	135,694	1,370,237	0	1,370,237	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,144	77,407	155,551	0	155,551	14.00
15.00	01500	PHARMACY	463,358	3,680,130	4,143,488	0	4,143,488	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	509,664	254,711	764,375	0	764,375	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,741,389	348,935	3,090,324	-196,211	2,894,113	30.00
31.00	03100	INTENSIVE CARE UNIT	1,048,517	216,459	1,264,976	0	1,264,976	31.00
41.00	04100	SUBPROVIDER - IRF	640,538	178,947	819,485	0	819,485	41.00
43.00	04300	NURSERY	0	0	0	196,211	196,211	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,669,928	763,875	2,433,803	0	2,433,803	50.00
53.00	05300	ANESTHESIOLOGY	0	26,332	26,332	0	26,332	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,968,309	995,479	2,963,788	0	2,963,788	54.00
60.00	06000	LABORATORY	1,279,363	1,889,737	3,169,100	0	3,169,100	60.00
65.00	06500	RESPIRATORY THERAPY	850,914	152,188	1,003,102	0	1,003,102	65.00
66.00	06600	PHYSICAL THERAPY	717,019	33,533	750,552	0	750,552	66.00
67.00	06700	OCCUPATIONAL THERAPY	205,640	-1,331	204,309	0	204,309	67.00
68.00	06800	SPEECH PATHOLOGY	128,337	57	128,394	0	128,394	68.00
69.00	06900	ELECTROCARDIOLOGY	341,538	417,148	758,686	0	758,686	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,765	9,060	55,825	0	55,825	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,101,069	3,101,069	-1,305,191	1,795,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,305,191	1,305,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	195,362	29,203	224,565	0	224,565	76.00
76.97	07697	CARDIAC REHABILITATION	93,855	8,626	102,481	0	102,481	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	572,857	1,831,573	2,404,430	0	2,404,430	90.00
91.00	09100	EMERGENCY	1,707,964	349,587	2,057,551	0	2,057,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	641,537	168,106	809,643	0	809,643	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		11,286	11,286	0	11,286	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,417,383	38,808,609	63,225,992	145,487	63,371,479	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	57,144	48,521	105,665	0	105,665	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,348,922	2,805,648	11,154,570	0	11,154,570	192.00
192.01	19201	SOUTH CLINIC	0	15	15	0	15	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	86,052	6,742	92,794	0	92,794	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	526,161	82,100	608,261	-145,487	462,774	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	784,999	784,999	0	784,999	193.03
194.00	07950	PARTNERSHIP HFC	46,044	6,256	52,300	0	52,300	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	53,031	53,031	0	53,031	194.03
194.04	07954	ATHLETIC TRAINERS	116,379	27,825	144,204	0	144,204	194.04
200.00		TOTAL (SUM OF LINES 118-199)	33,598,085	42,623,746	76,221,831	0	76,221,831	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/21/2015 1:29 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	83,232	1,789,975		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	86,509		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,718,329		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-158,486	8,271,723		4.00
4.01	00401	COMMUNICATIONS	-16,338	449,219		4.01
4.02	00402	DATA PROCESSING	0	1,390,420		4.02
4.03	00403	MATERIALS MANAGEMENT	0	312,653		4.03
4.04	00404	ADMITTING	0	609,372		4.04
4.05	00405	PATIENT ACCOUNTING	0	1,404,427		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	-834,876	8,727,921		5.00
7.00	00700	OPERATION OF PLANT	-41,564	2,849,212		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	189,383		8.00
9.00	00900	HOUSEKEEPING	0	744,981		9.00
10.00	01000	DIETARY	-405	463,238		10.00
11.00	01100	CAFETERIA	-276,298	306,030		11.00
13.00	01300	NURSING ADMINISTRATION	-68	1,370,169		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	155,551		14.00
15.00	01500	PHARMACY	-5,025	4,138,463		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,789	743,586		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,894,113		30.00
31.00	03100	INTENSIVE CARE UNIT	385	1,265,361		31.00
41.00	04100	SUBPROVIDER - IRF	-2,689	816,796		41.00
43.00	04300	NURSERY	0	196,211		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-38,184	2,395,619		50.00
53.00	05300	ANESTHESIOLOGY	0	26,332		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,132	2,960,656		54.00
60.00	06000	LABORATORY	0	3,169,100		60.00
65.00	06500	RESPIRATORY THERAPY	-7,000	996,102		65.00
66.00	06600	PHYSICAL THERAPY	0	750,552		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	204,309		67.00
68.00	06800	SPEECH PATHOLOGY	0	128,394		68.00
69.00	06900	ELECTROCARDIOLOGY	-59,350	699,336		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	55,825		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,795,878		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,305,191		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ONCOLOGY	0	224,565		76.00
76.97	07697	CARDIAC REHABILITATION	0	102,481		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-135,461	2,268,969		90.00
91.00	09100	EMERGENCY	-131,739	1,925,812		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	809,643		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-11,286	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,659,073	61,712,406		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	105,665		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,154,570		192.00
192.01	19201	SOUTH CLINIC	0	15		192.01
192.02	19202	WEST CLINIC	0	0		192.02
192.03	19203	DIABETES CENTER	0	92,794		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	462,774		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	784,999		193.03
194.00	07950	PARTNERSHIP HFC	0	52,300		194.00
194.01	07951	TRAFALGAR CLINIC	0	0		194.01
194.02	07952	EDINBURGH	0	0		194.02
194.03	07953	JAIL	0	53,031		194.03
194.04	07954	ATHLETIC TRAINERS	0	144,204		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,659,073	74,562,758		200.00

RECLASSIFICATIONS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/21/2015 1:29 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	413,654	168,674		1.00
	TOTALS		413,654	168,674		
	B - CHILD CARE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	125,850	19,637		1.00
	TOTALS		125,850	19,637		
	C - NURSERY RECLASS					
1.00	NURSERY	43.00	169,363	26,848		1.00
	TOTALS		169,363	26,848		
	D - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,305,191		1.00
	TOTALS		0	1,305,191		
500.00	Grand Total: Increases		708,867	1,520,350		500.00

RECLASSIFICATIONS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/21/2015 1:29 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	413,654	168,674	0		1.00
	TOTALS		413,654	168,674			
	B - CHILD CARE RECLASS						
1.00	ADULT/CHILD CARE	193.01	125,850	19,637	0		1.00
	TOTALS		125,850	19,637			
	C - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	169,363	26,848	0		1.00
	TOTALS		169,363	26,848			
	D - IMPLANTABLE DEVICE RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,305,191	0		1.00
	TOTALS		0	1,305,191			
500.00	Grand Total: Decreases		708,867	1,520,350			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/21/2015 1:29 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,141,963	0	0	0	0	1.00
2.00	Land Improvements	1,604,444	0	0	0	579	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	65,603,416	3,616,100	-480,766	3,135,334	0	4.00
5.00	Fixed Equipment	11,410,038	280,245	0	280,245	0	5.00
6.00	Movable Equipment	36,763,492	1,266,514	480,766	1,747,280	2,283,742	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	118,523,353	5,162,859	0	5,162,859	2,284,321	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	118,523,353	5,162,859	0	5,162,859	2,284,321	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,141,963	0	1.00
2.00	Land Improvements	1,603,865	0	2.00
3.00	Buildings and Fixtures	0	0	3.00
4.00	Building Improvements	68,738,750	0	4.00
5.00	Fixed Equipment	11,690,283	0	5.00
6.00	Movable Equipment	36,227,030	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	121,401,891	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	121,401,891	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/21/2015 1:29 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	1,706,743	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	86,509	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,718,329	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,511,581	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,706,743	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	86,509	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,718,329	2.00
3.00	Total (sum of lines 1-2)	0	4,511,581	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/21/2015 1:29 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	85,174,861	0	85,174,861	0.701594	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	36,227,030	0	36,227,030	0.298406	0	2.00
3.00	Total (sum of lines 1-2)	121,401,891	0	121,401,891	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,789,975	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	86,509	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,718,329	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,594,813	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,789,975	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0	86,509	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,718,329	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	4,594,813	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/21/2015 1:29 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
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - TOWER (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-777,639			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		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT - TOWER		0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/21/2015 1:29 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	JMH PAIN CARE CENTER REV OPERATING F	B	-132,810	CLINIC	90.00	0	33.00
34.00	JMH NUTR SVCS DISCOUNTS OPERATING FU	B	63	DIETARY	10.00	0	34.00
35.00	JMH PURCHASES DISCOUNTS OPERATING FU	B	-4,257	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	JMH SALE OF FILM	B	-132	RADIOLOGY-DIAGNOSTIC	54.00	0	36.00
37.00	JMH CAFETERIA REV OPERATING FUND	B	-276,298	CAFETERIA	11.00	0	37.00
38.00	JMH CATERING REV OPERATING FUND	B	-468	DIETARY	10.00	0	38.00
39.00	JMH MISC PHARM REVENUE OPERATING FUN	B	-5,025	PHARMACY	15.00	0	39.00
40.00	JMH RENT OF SPACE	B	-3,600	OPERATION OF PLANT	7.00	0	40.00
41.00	JMH MEDICAL RECORD FEES OPERATING FU	B	-20,789	MEDICAL RECORDS & LIBRARY	16.00	0	41.00
42.00	JMH GEN ACCOUNTING REV OPERATING FUN	B	-6,622	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	JMH RETURNED CHECK FEES OPERATING FU	B	-350	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	JMH EDUCATION PROGRAMS OPERATING FUN	B	-68	NURSING ADMINISTRATION	13.00	0	44.00
45.00	1993 AHA LIFE ADJUSTMENT	A	84,563	CAP REL COSTS-BLDG & FIXT	1.00	9	45.00
45.01	MED STAFF OTHER EXP	A	-3,042	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	CABLE SERVICES	A	-24,549	OPERATION OF PLANT	7.00	0	45.02
45.03	TELEPHONE SERVICES	A	-1,331	CAP REL COSTS-BLDG & FIXT	1.00	9	45.03
45.04	TELEPHONE SERVICES	A	-18,371	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	COMMUNICATIONS	A	-16,338	COMMUNICATIONS	4.01	0	45.05
45.06	ADVERTISING EXP-A&G	A	-259,563	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.08	ADVERTISING EXP -ARU	A	-1,493	SUBPROVIDER - IRF	41.00	0	45.08
45.09	ADVERTISING EXP-WOUND CARE	A	-2,651	CLINIC	90.00	0	45.09
45.13	DAYCARE	B	-154,732	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.13
45.14	LOBBYING EXPENSE-AHA	A	-3,726	ADMINISTRATIVE & GENERAL	5.00	0	45.14
45.15	LOBBYING EXPENSE-IHHA	A	-1,390	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	PROF - BUILDING	A	-13,415	OPERATION OF PLANT	7.00	0	45.16
45.17	PROF - BUILDING	A	-3,754	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.17
45.19	INTEREST INCOME	B	-11,286	INTEREST EXPENSE	113.00	0	45.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,659,073				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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/21/2015 1:29 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	5.00	ADMINISTRATIVE & GENERAL	537,555	537,555	0	225,300	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	-25	-385	360	225,300	6	2.00
3.00	41.00	SUBPROVIDER - IRF	106,480	0	106,480	225,300	972	3.00
4.00	50.00	OPERATING ROOM	42,083	30,083	12,000	225,300	36	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	3,000	3,000	0	225,300	0	5.00
6.00	60.00	LABORATORY	110,004	0	110,004	215,700	1,575	6.00
7.00	65.00	RESPIRATORY THERAPY	7,000	7,000	0	225,300	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	59,350	59,350	0	225,300	0	8.00
9.00	91.00	EMERGENCY	136,387	131,739	4,648	225,300	72	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,001,834	768,342	233,492		2,661	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	650	33	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	105,284	5,264	0	0	0	3.00
4.00	50.00	OPERATING ROOM	3,899	195	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	163,331	8,167	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	7,799	390	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			280,963	14,049	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	537,555		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	650	0	-385		2.00
3.00	41.00	SUBPROVIDER - IRF	0	105,284	1,196	1,196		3.00
4.00	50.00	OPERATING ROOM	0	3,899	8,101	38,184		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,000		5.00
6.00	60.00	LABORATORY	0	163,331	0	0		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	7,000		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	59,350		8.00
9.00	91.00	EMERGENCY	0	7,799	0	131,739		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	280,963	9,297	777,639		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,789,975	1,789,975				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	86,509	0	86,509			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,718,329			2,718,329		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,271,723	19,102	0	2,197	8,293,022	4.00
4.01	00401	COMMUNICATIONS	449,219	2,516	0	0	48,229	4.01
4.02	00402	DATA PROCESSING	1,390,420	40,074	0	1,115,117	181,603	4.02
4.03	00403	MATERIALS MANAGEMENT	312,653	24,492	0	5,759	67,421	4.03
4.04	00404	ADMITTING	609,372	14,333	1,842	0	147,670	4.04
4.05	00405	PATIENT ACCOUNTING	1,404,427	42,570	0	2,074	217,380	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	8,727,921	60,981	0	12,041	472,990	5.00
7.00	00700	OPERATION OF PLANT	2,849,212	159,783	12,498	36,200	162,745	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	189,383	15,389	0	4,783	28,666	8.00
9.00	00900	HOUSEKEEPING	744,981	11,952	937	2,493	158,722	9.00
10.00	01000	DIETARY	463,238	25,075	554	22,176	83,244	10.00
11.00	01100	CAFETERIA	306,030	26,701	0	0	104,554	11.00
13.00	01300	NURSING ADMINISTRATION	1,370,169	63,164	0	33,285	312,039	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	155,551	10,876	0	35,482	19,751	14.00
15.00	01500	PHARMACY	4,138,463	13,098	0	4,069	117,117	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	743,586	24,832	0	6,734	128,821	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,894,113	176,535	19,566	196,926	650,098	30.00
31.00	03100	INTENSIVE CARE UNIT	1,265,361	50,483	8,861	92,792	265,020	31.00
41.00	04100	SUBPROVIDER - IRF	816,796	43,294	7,599	14,963	161,900	41.00
43.00	04300	NURSERY	196,211	4,001	0	0	42,808	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,395,619	292,942	802	459,721	422,086	50.00
53.00	05300	ANESTHESIOLOGY	26,332	2,522	0	29,710	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,960,656	105,830	12,062	271,096	497,504	54.00
60.00	06000	LABORATORY	3,169,100	51,526	6,924	113,004	323,368	60.00
65.00	06500	RESPIRATORY THERAPY	996,102	21,599	1,203	27,625	215,074	65.00
66.00	06600	PHYSICAL THERAPY	750,552	40,573	0	8,485	181,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	204,309	8,546	0	3,419	51,977	67.00
68.00	06800	SPEECH PATHOLOGY	128,394	531	93	358	32,438	68.00
69.00	06900	ELECTROCARDIOLOGY	699,336	6,914	99	58,266	86,326	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,825	1,165	204	4,553	11,820	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,795,878	0	0	21,161	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,305,191	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	224,565	44,804	0	6,565	49,379	76.00
76.97	07697	CARDIAC REHABILITATION	102,481	16,074	0	3,093	23,723	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,268,969	73,720	496	32,052	144,794	90.00
91.00	09100	EMERGENCY	1,925,812	63,593	10,860	62,527	431,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	809,643	8,354	0	963	162,153	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,712,406	1,567,944	84,600	2,689,689	6,004,352	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	105,665	8,303	1,457	2,440	14,444	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,154,570	165,960	0	26,021	2,110,241	192.00
192.01	19201	SOUTH CLINIC	15	0	0	179	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	92,794	2,573	452	0	21,750	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	462,774	30,932	0	0	101,181	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	784,999	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	52,300	14,263	0	0	11,638	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	53,031	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	144,204	0	0	0	29,416	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	74,562,758	1,789,975	86,509	2,718,329	8,293,022	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	
			4.01	4.02	4.03	4.04	4.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS	499,964					4.01
4.02	00402	DATA PROCESSING	59,200	2,786,414				4.02
4.03	00403	MATERIALS MANAGEMENT	10,694	33,673	454,692			4.03
4.04	00404	ADMITTING	9,167	146,266	1,731	930,381		4.04
4.05	00405	PATIENT ACCOUNTING	31,701	366,189	2,508	0	2,066,849	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	28,646	271,486	9,812	0	0	5.00
7.00	00700	OPERATION OF PLANT	14,896	31,568	89	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,910	7,366	1,332	0	0	8.00
9.00	00900	HOUSEKEEPING	5,347	0	6,610	0	0	9.00
10.00	01000	DIETARY	9,549	76,816	413	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,042	85,234	3,172	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	3,975	0	0	14.00
15.00	01500	PHARMACY	6,493	22,098	6,872	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,660	155,736	359	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,812	203,088	12,125	61,767	137,214	30.00
31.00	03100	INTENSIVE CARE UNIT	10,694	63,136	3,741	10,362	23,020	31.00
41.00	04100	SUBPROVIDER - IRF	6,875	59,979	938	9,214	20,468	41.00
43.00	04300	NURSERY	0	0	0	3,211	7,134	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,937	212,559	29,934	148,362	329,585	50.00
53.00	05300	ANESTHESIOLOGY	0	0	402	13,635	30,290	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,861	146,266	20,874	184,032	408,843	54.00
60.00	06000	LABORATORY	25,972	98,913	76,393	135,374	300,731	60.00
65.00	06500	RESPIRATORY THERAPY	6,875	87,339	7,333	30,006	66,657	65.00
66.00	06600	PHYSICAL THERAPY	8,021	31,568	1,311	17,377	38,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,528	1,052	0	9,420	20,927	67.00
68.00	06800	SPEECH PATHOLOGY	1,528	6,314	1	2,990	6,643	68.00
69.00	06900	ELECTROCARDIOLOGY	15,278	77,868	4,653	28,280	62,825	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	764	3,157	71	967	2,149	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	215,491	32,681	72,600	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,165	51,460	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,305	153,960	73.00
76.00	03020	ONCOLOGY	14,132	30,516	517	5,505	12,228	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	424	1,851	4,111	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,875	109,436	21,968	42,731	94,927	90.00
91.00	09100	EMERGENCY	21,389	85,234	5,822	92,530	205,554	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,021	46,300	880	7,616	16,920	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	425,867	2,459,157	439,751	930,381	2,066,849	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,729	33,673	60	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	58,437	208,350	14,456	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	1	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	1,146	9,470	26	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	5,729	34,725	255	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	3,056	41,039	93	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	50	0	0	194.04
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)	499,964	2,786,414	454,692	930,381	2,066,849	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A.05	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,583,877	9,583,877				5.00
7.00	00700	OPERATION OF PLANT	3,266,991	481,855	3,748,846			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	248,829	36,700	40,454	325,983		8.00
9.00	00900	HOUSEKEEPING	931,042	137,321	31,417	52,820	1,152,600	9.00
10.00	01000	DIETARY	681,065	100,452	65,914	5,030	20,662	10.00
11.00	01100	CAFETERIA	437,285	64,496	70,188	0	22,002	11.00
13.00	01300	NURSING ADMINISTRATION	1,883,105	277,743	166,039	0	52,047	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	225,635	33,279	28,590	0	8,962	14.00
15.00	01500	PHARMACY	4,308,210	635,427	34,430	0	10,792	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,075,728	158,661	65,275	0	20,461	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,389,244	647,378	464,058	99,840	145,466	30.00
31.00	03100	INTENSIVE CARE UNIT	1,793,470	264,522	132,703	20,089	41,598	31.00
41.00	04100	SUBPROVIDER - IRF	1,142,026	168,440	113,806	13,491	35,674	41.00
43.00	04300	NURSERY	253,365	37,369	10,517	0	3,297	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,322,547	637,541	770,053	57,194	241,384	50.00
53.00	05300	ANESTHESIOLOGY	102,891	15,176	6,630	0	2,078	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,627,024	682,449	278,196	19,907	87,204	54.00
60.00	06000	LABORATORY	4,301,305	634,408	135,446	0	42,458	60.00
65.00	06500	RESPIRATORY THERAPY	1,459,813	215,311	56,777	0	17,797	65.00
66.00	06600	PHYSICAL THERAPY	1,077,722	158,955	106,654	1,785	33,432	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,178	44,421	22,465	0	7,042	67.00
68.00	06800	SPEECH PATHOLOGY	179,290	26,444	1,397	0	438	68.00
69.00	06900	ELECTROCARDIOLOGY	1,039,845	153,369	18,174	2,737	5,697	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,675	11,899	3,063	0	960	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,137,811	315,310	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,379,816	203,512	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	223,265	32,930	0	0	0	73.00
76.00	03020	ONCOLOGY	388,211	57,258	117,777	0	36,919	76.00
76.97	07697	CARDIAC REHABILITATION	151,757	22,383	42,254	0	13,245	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,795,968	412,383	193,788	1,705	60,746	90.00
91.00	09100	EMERGENCY	2,905,021	428,467	167,167	45,900	52,401	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,060,850	156,467	21,960	0	6,884	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,754,861	7,252,326	3,165,192	320,498	969,646	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	171,771	25,335	21,826	0	6,842	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,738,035	2,026,263	436,259	5,485	136,751	192.00
192.01	19201	SOUTH CLINIC	195	29	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	128,211	18,910	6,765	0	2,121	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	635,596	93,745	81,312	0	25,488	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	784,999	115,781	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	122,389	18,051	37,492	0	11,752	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	53,031	7,822	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	173,670	25,615	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	74,562,758	9,583,877	3,748,846	325,983	1,152,600	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
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	873,123					10.00
11.00	01100	CAFETERIA	0	593,971				11.00
13.00	01300	NURSING ADMINISTRATION	0	16,553	2,395,487			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,229	0	299,695		14.00
15.00	01500	PHARMACY	0	9,776	0	0	4,998,635	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,745	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	573,766	73,929	846,236	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	96,585	27,303	312,532	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	136,217	18,079	206,944	0	0	41.00
43.00	04300	NURSERY	66,555	4,555	52,144	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	45,357	496,131	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,849	0	0	0	54.00
60.00	06000	LABORATORY	0	45,102	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	21,748	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,697	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,851	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,656	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,866	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,336	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	299,695	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	4,998,635	73.00
76.00	03020	ONCOLOGY	0	5,539	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,308	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	19,603	0	0	0	90.00
91.00	09100	EMERGENCY	0	42,485	481,500	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	16,757	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	873,123	456,323	2,395,487	299,695	4,998,635	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,471	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	100,728	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	2,070	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	22,224	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	5,512	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	4,643	0	0	0	194.04
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)	873,123	593,971	2,395,487	299,695	4,998,635	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
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	1,340,870					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	89,015	7,328,932	0	7,328,932		30.00
31.00	03100	INTENSIVE CARE UNIT	14,933	2,703,735	0	2,703,735		31.00
41.00	04100	SUBPROVIDER - IRF	13,278	1,847,955	0	1,847,955		41.00
43.00	04300	NURSERY	4,628	432,430	0	432,430		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	213,811	6,784,018	0	6,784,018		50.00
53.00	05300	ANESTHESIOLOGY	19,650	146,425	0	146,425		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	265,276	6,008,905	0	6,008,905		54.00
60.00	06000	LABORATORY	195,093	5,353,812	0	5,353,812		60.00
65.00	06500	RESPIRATORY THERAPY	43,242	1,814,688	0	1,814,688		65.00
66.00	06600	PHYSICAL THERAPY	25,043	1,421,288	0	1,421,288		66.00
67.00	06700	OCCUPATIONAL THERAPY	13,576	393,533	0	393,533		67.00
68.00	06800	SPEECH PATHOLOGY	4,309	214,534	0	214,534		68.00
69.00	06900	ELECTROCARDIOLOGY	40,756	1,268,444	0	1,268,444		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,394	99,327	0	99,327		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,097	2,799,913	0	2,799,913		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,384	1,616,712	0	1,616,712		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	99,878	5,354,708	0	5,354,708		73.00
76.00	03020	ONCOLOGY	7,933	613,637	0	613,637		76.00
76.97	07697	CARDIAC REHABILITATION	2,667	234,614	0	234,614		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	61,582	3,545,775	0	3,545,775		90.00
91.00	09100	EMERGENCY	133,349	4,256,290	0	4,256,290		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	10,976	1,273,894	0	1,273,894		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,340,870	55,513,569	0	55,513,569		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	228,245	0	228,245		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16,443,521	0	16,443,521		192.00
192.01	19201	SOUTH CLINIC	0	224	0	224		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	158,077	0	158,077		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	858,365	0	858,365		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	900,780	0	900,780		193.03
194.00	07950	PARTNERSHIP HFC	0	195,196	0	195,196		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	60,853	0	60,853		194.03
194.04	07954	ATHLETIC TRAINERS	0	203,928	0	203,928		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,340,870	74,562,758	0	74,562,758		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,102	0	2,197	21,299	4.00
4.01	00401	COMMUNICATIONS	0	2,516	0	0	2,516	4.01
4.02	00402	DATA PROCESSING	0	40,074	0	1,115,117	1,155,191	4.02
4.03	00403	MATERIALS MANAGEMENT	0	24,492	0	5,759	30,251	4.03
4.04	00404	ADMITTING	0	14,333	1,842	0	16,175	4.04
4.05	00405	PATIENT ACCOUNTING	0	42,570	0	2,074	44,644	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	60,981	0	12,041	73,022	5.00
7.00	00700	OPERATION OF PLANT	0	159,783	12,498	36,200	208,481	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,389	0	4,783	20,172	8.00
9.00	00900	HOUSEKEEPING	0	11,952	937	2,493	15,382	9.00
10.00	01000	DIETARY	0	25,075	554	22,176	47,805	10.00
11.00	01100	CAFETERIA	0	26,701	0	0	26,701	11.00
13.00	01300	NURSING ADMINISTRATION	0	63,164	0	33,285	96,449	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,876	0	35,482	46,358	14.00
15.00	01500	PHARMACY	0	13,098	0	4,069	17,167	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,832	0	6,734	31,566	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	176,535	19,566	196,926	393,027	30.00
31.00	03100	INTENSIVE CARE UNIT	0	50,483	8,861	92,792	152,136	31.00
41.00	04100	SUBPROVIDER - IRF	0	43,294	7,599	14,963	65,856	41.00
43.00	04300	NURSERY	0	4,001	0	0	4,001	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	292,942	802	459,721	753,465	50.00
53.00	05300	ANESTHESIOLOGY	0	2,522	0	29,710	32,232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	105,830	12,062	271,096	388,988	54.00
60.00	06000	LABORATORY	0	51,526	6,924	113,004	171,454	60.00
65.00	06500	RESPIRATORY THERAPY	0	21,599	1,203	27,625	50,427	65.00
66.00	06600	PHYSICAL THERAPY	0	40,573	0	8,485	49,058	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,546	0	3,419	11,965	67.00
68.00	06800	SPEECH PATHOLOGY	0	531	93	358	982	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,914	99	58,266	65,279	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,165	204	4,553	5,922	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	21,161	21,161	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
76.00	03020	ONCOLOGY	0	44,804	0	6,565	51,369	76.00
76.97	07697	CARDIAC REHABILITATION	0	16,074	0	3,093	19,167	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	73,720	496	32,052	106,268	90.00
91.00	09100	EMERGENCY	0	63,593	10,860	62,527	136,980	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8,354	0	963	9,317	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,567,944	84,600	2,689,689	4,342,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,303	1,457	2,440	12,200	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	165,960	0	26,021	191,981	192.00
192.01	19201	SOUTH CLINIC	0	0	0	179	179	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	2,573	452	0	3,025	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	30,932	0	0	30,932	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	14,263	0	0	14,263	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	0	0	194.04
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	1,789,975	86,509	2,718,329	4,594,813	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	
			4.00	4.01	4.02	4.03	4.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,299					4.00
4.01	00401	COMMUNICATIONS	124	2,640				4.01
4.02	00402	DATA PROCESSING	466	316	1,155,973			4.02
4.03	00403	MATERIALS MANAGEMENT	173	56	13,969	44,449		4.03
4.04	00404	ADMITTING	379	48	60,680	169	77,451	4.04
4.05	00405	PATIENT ACCOUNTING	558	167	151,920	245	0	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	1,214	151	112,629	959	0	5.00
7.00	00700	OPERATION OF PLANT	418	79	13,096	9	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74	10	3,056	130	0	8.00
9.00	00900	HOUSEKEEPING	408	28	0	646	0	9.00
10.00	01000	DIETARY	214	50	31,868	40	0	10.00
11.00	01100	CAFETERIA	268	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	801	85	35,360	310	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	51	0	0	389	0	14.00
15.00	01500	PHARMACY	301	34	9,167	672	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	331	83	64,609	35	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,669	200	84,253	1,185	5,142	30.00
31.00	03100	INTENSIVE CARE UNIT	680	56	26,193	366	863	31.00
41.00	04100	SUBPROVIDER - IRF	416	36	24,883	92	767	41.00
43.00	04300	NURSERY	110	0	0	0	267	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,084	163	88,182	2,926	12,350	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	39	1,135	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,277	105	60,680	2,041	15,324	54.00
60.00	06000	LABORATORY	830	137	41,035	7,468	11,269	60.00
65.00	06500	RESPIRATORY THERAPY	552	36	36,233	717	2,498	65.00
66.00	06600	PHYSICAL THERAPY	465	42	13,096	128	1,446	66.00
67.00	06700	OCCUPATIONAL THERAPY	133	8	437	0	784	67.00
68.00	06800	SPEECH PATHOLOGY	83	8	2,619	0	249	68.00
69.00	06900	ELECTROCARDIOLOGY	222	81	32,304	455	2,354	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30	4	1,310	7	81	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	21,067	2,720	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,928	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,769	73.00
76.00	03020	ONCOLOGY	127	75	12,660	50	458	76.00
76.97	07697	CARDIAC REHABILITATION	61	0	0	41	154	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	372	36	45,401	2,147	3,557	90.00
91.00	09100	EMERGENCY	1,108	113	35,360	569	7,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	416	42	19,208	86	634	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,415	2,249	1,020,208	42,988	77,451	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37	30	13,969	6	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,425	309	86,436	1,413	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	56	6	3,929	3	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	260	30	14,406	25	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	30	16	17,025	9	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	76	0	0	5	0	194.04
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)	21,299	2,640	1,155,973	44,449	77,451	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.05	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING	197,534					4.05
5.00	00500	ADMINISTRATIVE & GENERAL	0	187,975				5.00
7.00	00700	OPERATION OF PLANT	0	9,451	231,534			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	720	2,498	26,660		8.00
9.00	00900	HOUSEKEEPING	0	2,694	1,940	4,320	25,418	9.00
10.00	01000	DIETARY	0	1,970	4,071	411	456	10.00
11.00	01100	CAFETERIA	0	1,265	4,335	0	485	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,448	10,255	0	1,148	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	653	1,766	0	198	14.00
15.00	01500	PHARMACY	0	12,464	2,126	0	238	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,112	4,031	0	451	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,114	12,698	28,661	8,166	3,208	30.00
31.00	03100	INTENSIVE CARE UNIT	2,200	5,189	8,196	1,643	917	31.00
41.00	04100	SUBPROVIDER - IRF	1,956	3,304	7,029	1,103	787	41.00
43.00	04300	NURSERY	682	733	650	0	73	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,500	12,505	47,561	4,677	5,322	50.00
53.00	05300	ANESTHESIOLOGY	2,895	298	409	0	46	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,069	13,386	17,182	1,628	1,923	54.00
60.00	06000	LABORATORY	28,743	12,444	8,365	0	936	60.00
65.00	06500	RESPIRATORY THERAPY	6,371	4,223	3,507	0	392	65.00
66.00	06600	PHYSICAL THERAPY	3,689	3,118	6,587	146	737	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,000	871	1,387	0	155	67.00
68.00	06800	SPEECH PATHOLOGY	635	519	86	0	10	68.00
69.00	06900	ELECTROCARDIOLOGY	6,005	3,008	1,122	224	126	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	205	233	189	0	21	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,939	6,185	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,918	3,992	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,715	646	0	0	0	73.00
76.00	03020	ONCOLOGY	1,169	1,123	7,274	0	814	76.00
76.97	07697	CARDIAC REHABILITATION	393	439	2,610	0	292	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,073	8,089	11,969	139	1,340	90.00
91.00	09100	EMERGENCY	19,646	8,404	10,324	3,754	1,156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,617	3,069	1,356	0	152	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	197,534	142,253	195,486	26,211	21,383	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	497	1,348	0	151	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39,734	26,944	449	3,016	192.00
192.01	19201	SOUTH CLINIC	0	1	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	371	418	0	47	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	1,839	5,022	0	562	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	2,271	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	354	2,316	0	259	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	153	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	502	0	0	0	194.04
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)	197,534	187,975	231,534	26,660	25,418	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
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	86,885					10.00
11.00	01100	CAFETERIA	0	33,054				11.00
13.00	01300	NURSING ADMINISTRATION	0	921	150,777			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	180	0	49,595		14.00
15.00	01500	PHARMACY	0	544	0	0	42,713	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,154	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,096	4,114	53,264	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,611	1,519	19,671	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	13,555	1,006	13,025	0	0	41.00
43.00	04300	NURSERY	6,623	254	3,282	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,524	31,228	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,718	0	0	0	54.00
60.00	06000	LABORATORY	0	2,510	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,210	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	985	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	270	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	148	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	438	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	74	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	49,595	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	42,713	73.00
76.00	03020	ONCOLOGY	0	308	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	128	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,091	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,364	30,307	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	933	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,885	25,393	150,777	49,595	42,713	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	138	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,606	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	0	115	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	0	1,237	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	0	307	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	258	0	0	0	194.04
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)	86,885	33,054	150,777	49,595	42,713	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
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	105,372					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,999	672,796	0	672,796		30.00
31.00	03100	INTENSIVE CARE UNIT	1,174	230,414	0	230,414		31.00
41.00	04100	SUBPROVIDER - IRF	1,044	134,859	0	134,859		41.00
43.00	04300	NURSERY	364	17,039	0	17,039		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,811	1,010,298	0	1,010,298		50.00
53.00	05300	ANESTHESIOLOGY	1,545	38,599	0	38,599		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,802	565,123	0	565,123		54.00
60.00	06000	LABORATORY	15,339	300,530	0	300,530		60.00
65.00	06500	RESPIRATORY THERAPY	3,400	109,566	0	109,566		65.00
66.00	06600	PHYSICAL THERAPY	1,969	81,466	0	81,466		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,067	19,077	0	19,077		67.00
68.00	06800	SPEECH PATHOLOGY	339	5,678	0	5,678		68.00
69.00	06900	ELECTROCARDIOLOGY	3,204	114,822	0	114,822		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	110	8,186	0	8,186		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,703	111,370	0	111,370		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,625	13,463	0	13,463		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,853	71,696	0	71,696		73.00
76.00	03020	ONCOLOGY	624	76,051	0	76,051		76.00
76.97	07697	CARDIAC REHABILITATION	210	23,495	0	23,495		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,842	194,324	0	194,324		90.00
91.00	09100	EMERGENCY	10,485	268,272	0	268,272		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	863	37,693	0	37,693		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	105,372	4,104,817	0	4,104,817		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,376	0	28,376		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	361,313	0	361,313		192.00
192.01	19201	SOUTH CLINIC	0	180	0	180		192.01
192.02	19202	WEST CLINIC	0	0	0	0		192.02
192.03	19203	DIABETES CENTER	0	7,970	0	7,970		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	ADULT/CHILD CARE	0	54,313	0	54,313		193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0		193.02
193.03	19303	OPTIFAST/FOUNDATION	0	2,271	0	2,271		193.03
194.00	07950	PARTNERSHIP HFC	0	34,579	0	34,579		194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0		194.01
194.02	07952	EDINBURGH	0	0	0	0		194.02
194.03	07953	JAIL	0	153	0	153		194.03
194.04	07954	ATHLETIC TRAINERS	0	841	0	841		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	105,372	4,594,813	0	4,594,813		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	
			1.00	1.01	2.00	4.00	4.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	279,616					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER	0	76,991				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2,451,250			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,984	0	1,981	32,810,284		4.00
4.01	00401	COMMUNICATIONS	393	0	0	190,811	1,309	4.01
4.02	00402	DATA PROCESSING	6,260	0	1,005,557	718,487	155	4.02
4.03	00403	MATERIALS MANAGEMENT	3,826	0	5,193	266,743	28	4.03
4.04	00404	ADMITTING	2,239	1,639	0	584,236	24	4.04
4.05	00405	PATIENT ACCOUNTING	6,650	0	1,870	860,037	83	4.05
5.00	00500	ADMINISTRATIVE & GENERAL	9,526	0	10,858	1,871,323	75	5.00
7.00	00700	OPERATION OF PLANT	24,960	11,123	32,643	643,881	39	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,404	0	4,313	113,414	5	8.00
9.00	00900	HOUSEKEEPING	1,867	834	2,248	627,961	14	9.00
10.00	01000	DIETARY	3,917	493	19,997	329,344	25	10.00
11.00	01100	CAFETERIA	4,171	0	0	413,654	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,867	0	30,015	1,234,543	42	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,699	0	31,996	78,144	0	14.00
15.00	01500	PHARMACY	2,046	0	3,669	463,358	17	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,879	0	6,072	509,664	41	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,577	17,413	177,578	2,572,026	99	30.00
31.00	03100	INTENSIVE CARE UNIT	7,886	7,886	83,675	1,048,517	28	31.00
41.00	04100	SUBPROVIDER - IRF	6,763	6,763	13,493	640,538	18	41.00
43.00	04300	NURSERY	625	0	0	169,363	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,761	714	414,553	1,669,928	81	50.00
53.00	05300	ANESTHESIOLOGY	394	0	26,791	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,532	10,735	244,461	1,968,309	52	54.00
60.00	06000	LABORATORY	8,049	6,162	101,901	1,279,363	68	60.00
65.00	06500	RESPIRATORY THERAPY	3,374	1,071	24,911	850,914	18	65.00
66.00	06600	PHYSICAL THERAPY	6,338	0	7,651	717,019	21	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,335	0	3,083	205,640	4	67.00
68.00	06800	SPEECH PATHOLOGY	83	83	323	128,337	4	68.00
69.00	06900	ELECTROCARDIOLOGY	1,080	88	52,541	341,538	40	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	182	182	4,106	46,765	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	19,082	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
76.00	03020	ONCOLOGY	6,999	0	5,920	195,362	37	76.00
76.97	07697	CARDIAC REHABILITATION	2,511	0	2,789	93,855	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,516	441	28,903	572,857	18	90.00
91.00	09100	EMERGENCY	9,934	9,665	56,384	1,707,964	56	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,305	0	868	641,537	21	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	244,932	75,292	2,425,425	23,755,432	1,115	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	1,297	2,200	57,144	15	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,925	0	23,464	8,348,922	153	192.00
192.01	19201	SOUTH CLINIC	0	0	161	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	402	402	0	86,052	3	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	4,832	0	0	400,311	15	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	2,228	0	0	46,044	8	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	0	0	116,379	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,789,975	86,509	2,718,329	8,293,022	499,964	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	
			1.00	1.01	2.00	4.00	4.01	
203.00		Unit cost multiplier (Wkst. B, Part I)	6.401547	1.123625	1.108956	0.252757	381.943468	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				21,299	2,640	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000649	2.016807	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	
			4.02	4.03	4.04	4.05	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING	2,648					4.02
4.03	00403	MATERIALS MANAGEMENT	32	6,463,363				4.03
4.04	00404	ADMITTING	139	24,601	170,591,811			4.04
4.05	00405	PATIENT ACCOUNTING	348	35,645	0	170,591,811		4.05
5.00	00500	ADMINISTRATIVE & GENERAL	258	139,479	0	0	-9,583,877	5.00
7.00	00700	OPERATION OF PLANT	30	1,259	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7	18,936	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	93,961	0	0	0	9.00
10.00	01000	DIETARY	73	5,876	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	81	45,096	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	56,500	0	0	0	14.00
15.00	01500	PHARMACY	21	97,685	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	148	5,100	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	193	172,357	11,325,028	11,325,028	0	30.00
31.00	03100	INTENSIVE CARE UNIT	60	53,183	1,899,932	1,899,932	0	31.00
41.00	04100	SUBPROVIDER - IRF	57	13,336	1,689,367	1,689,367	0	41.00
43.00	04300	NURSERY	0	0	588,823	588,823	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	202	425,503	27,202,463	27,202,463	0	50.00
53.00	05300	ANESTHESIOLOGY	0	5,719	2,500,035	2,500,035	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139	296,724	33,747,527	33,747,527	0	54.00
60.00	06000	LABORATORY	94	1,085,921	24,820,970	24,820,970	0	60.00
65.00	06500	RESPIRATORY THERAPY	83	104,237	5,501,585	5,501,585	0	65.00
66.00	06600	PHYSICAL THERAPY	30	18,632	3,186,095	3,186,095	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	1,727,224	1,727,224	0	67.00
68.00	06800	SPEECH PATHOLOGY	6	9	548,280	548,280	0	68.00
69.00	06900	ELECTROCARDIOLOGY	74	66,140	5,185,257	5,185,257	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3	1,009	177,329	177,329	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,063,184	5,992,038	5,992,038	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,247,286	4,247,286	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	12,707,166	12,707,166	0	73.00
76.00	03020	ONCOLOGY	29	7,342	1,009,281	1,009,281	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	6,030	339,307	339,307	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	104	312,265	7,834,869	7,834,869	0	90.00
91.00	09100	EMERGENCY	81	82,760	16,965,473	16,965,473	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	44	12,510	1,396,476	1,396,476	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,337	6,250,999	170,591,811	170,591,811	-9,583,877	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32	854	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	198	205,483	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	15	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	9	364	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	33	3,619	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	39	1,320	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	0	709	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,786,414	454,692	930,381	2,066,849		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,052.271148	0.070349	0.005454	0.012116		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,155,973	44,449	77,451	197,534		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	DATA PROCESSING (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	
			4.02	4.03	4.04	4.05	5A	
205.00		Unit cost multiplier (Wkst. B, Part II)	436.545695	0.006877	0.000454	0.001158		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
5.00	00500	ADMINISTRATIVE & GENERAL	64,978,881					5.00
7.00	00700	OPERATION OF PLANT	3,266,991	222,778				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	248,829	2,404	550,961			8.00
9.00	00900	HOUSEKEEPING	931,042	1,867	89,274	218,507		9.00
10.00	01000	DIETARY	681,065	3,917	8,502	3,917	9,275	10.00
11.00	01100	CAFETERIA	437,285	4,171	0	4,171	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,883,105	9,867	0	9,867	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	225,635	1,699	0	1,699	0	14.00
15.00	01500	PHARMACY	4,308,210	2,046	0	2,046	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,075,728	3,879	0	3,879	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,389,244	27,577	168,746	27,577	6,095	30.00
31.00	03100	INTENSIVE CARE UNIT	1,793,470	7,886	33,954	7,886	1,026	31.00
41.00	04100	SUBPROVIDER - IRF	1,142,026	6,763	22,801	6,763	1,447	41.00
43.00	04300	NURSERY	253,365	625	0	625	707	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,322,547	45,761	96,666	45,761	0	50.00
53.00	05300	ANESTHESIOLOGY	102,891	394	0	394	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,627,024	16,532	33,646	16,532	0	54.00
60.00	06000	LABORATORY	4,301,305	8,049	0	8,049	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,459,813	3,374	0	3,374	0	65.00
66.00	06600	PHYSICAL THERAPY	1,077,722	6,338	3,017	6,338	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	301,178	1,335	0	1,335	0	67.00
68.00	06800	SPEECH PATHOLOGY	179,290	83	0	83	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,039,845	1,080	4,626	1,080	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,675	182	0	182	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,137,811	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,379,816	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	223,265	0	0	0	0	73.00
76.00	03020	ONCOLOGY	388,211	6,999	0	6,999	0	76.00
76.97	07697	CARDIAC REHABILITATION	151,757	2,511	0	2,511	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,795,968	11,516	2,881	11,516	0	90.00
91.00	09100	EMERGENCY	2,905,021	9,934	77,578	9,934	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,060,850	1,305	0	1,305	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,170,984	188,094	541,691	183,823	9,275	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	171,771	1,297	0	1,297	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,738,035	25,925	9,270	25,925	0	192.00
192.01	19201	SOUTH CLINIC	195	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	128,211	402	0	402	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	635,596	4,832	0	4,832	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	784,999	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	122,389	2,228	0	2,228	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	53,031	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	173,670	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	9,583,877	3,748,846	325,983	1,152,600	873,123	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.147492	16.827721	0.591663	5.274888	94.137251	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	187,975	231,534	26,660	25,418	86,885	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 1:29 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.002893	1.039304	0.048388	0.116326	9.367655	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401	COMMUNICATIONS						4.01
4.02	00402	DATA PROCESSING						4.02
4.03	00403	MATERIALS MANAGEMENT						4.03
4.04	00404	ADMITTING						4.04
4.05	00405	PATIENT ACCOUNTING						4.05
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	795,102					11.00
13.00	01300	NURSING ADMINISTRATION	22,158	280,140				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,322	0	100			14.00
15.00	01500	PHARMACY	13,087	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,770	0	0	0	170,591,811	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	98,963	98,963	0	0	11,325,028	30.00
31.00	03100	INTENSIVE CARE UNIT	36,549	36,549	0	0	1,899,932	31.00
41.00	04100	SUBPROVIDER - IRF	24,201	24,201	0	0	1,689,367	41.00
43.00	04300	NURSERY	6,098	6,098	0	0	588,823	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,716	58,020	0	0	27,202,463	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,500,035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,391	0	0	0	33,747,527	54.00
60.00	06000	LABORATORY	60,375	0	0	0	24,820,970	60.00
65.00	06500	RESPIRATORY THERAPY	29,112	0	0	0	5,501,585	65.00
66.00	06600	PHYSICAL THERAPY	23,690	0	0	0	3,186,095	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,494	0	0	0	1,727,224	67.00
68.00	06800	SPEECH PATHOLOGY	3,555	0	0	0	548,280	68.00
69.00	06900	ELECTROCARDIOLOGY	10,530	0	0	0	5,185,257	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,788	0	0	0	177,329	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	100	0	5,992,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,247,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	12,707,166	73.00
76.00	03020	ONCOLOGY	7,414	0	0	0	1,009,281	76.00
76.97	07697	CARDIAC REHABILITATION	3,089	0	0	0	339,307	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,241	0	0	0	7,834,869	90.00
91.00	09100	EMERGENCY	56,871	56,309	0	0	16,965,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	22,431	0	0	0	1,396,476	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	610,845	280,140	100	100	170,591,811	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,308	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	134,835	0	0	0	0	192.00
192.01	19201	SOUTH CLINIC	0	0	0	0	0	192.01
192.02	19202	WEST CLINIC	0	0	0	0	0	192.02
192.03	19203	DIABETES CENTER	2,771	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT/CHILD CARE	29,750	0	0	0	0	193.01
193.02	19302	PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193.02
193.03	19303	OPTIFAST/FOUNDATION	0	0	0	0	0	193.03
194.00	07950	PARTNERSHIP HFC	7,378	0	0	0	0	194.00
194.01	07951	TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02	07952	EDINBURGH	0	0	0	0	0	194.02
194.03	07953	JAIL	0	0	0	0	0	194.03
194.04	07954	ATHLETIC TRAINERS	6,215	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	593,971	2,395,487	299,695	4,998,635	1,340,870	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.747037	8.551035	2,996.950000	49,986.350000	0.007860	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 1:29 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	33,054	150,777	49,595	42,713	105,372	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.041572	0.538220	495.950000	427.130000	0.000618	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,328,932		7,328,932	0	7,328,932	30.00
31.00	03100	INTENSIVE CARE UNIT	2,703,735		2,703,735	0	2,703,735	31.00
41.00	04100	SUBPROVIDER - IRF	1,847,955		1,847,955	1,196	1,849,151	41.00
43.00	04300	NURSERY	432,430		432,430	0	432,430	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,784,018		6,784,018	8,101	6,792,119	50.00
53.00	05300	ANESTHESIOLOGY	146,425		146,425	0	146,425	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,008,905		6,008,905	0	6,008,905	54.00
60.00	06000	LABORATORY	5,353,812		5,353,812	0	5,353,812	60.00
65.00	06500	RESPIRATORY THERAPY	1,814,688	0	1,814,688	0	1,814,688	65.00
66.00	06600	PHYSICAL THERAPY	1,421,288	0	1,421,288	0	1,421,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	393,533	0	393,533	0	393,533	67.00
68.00	06800	SPEECH PATHOLOGY	214,534	0	214,534	0	214,534	68.00
69.00	06900	ELECTROCARDIOLOGY	1,268,444		1,268,444	0	1,268,444	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	99,327		99,327	0	99,327	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,799,913		2,799,913	0	2,799,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,616,712		1,616,712	0	1,616,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,354,708		5,354,708	0	5,354,708	73.00
76.00	03020	ONCOLOGY	613,637		613,637	0	613,637	76.00
76.97	07697	CARDIAC REHABILITATION	234,614		234,614	0	234,614	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,545,775		3,545,775	0	3,545,775	90.00
91.00	09100	EMERGENCY	4,256,290		4,256,290	0	4,256,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,006,239		1,006,239		1,006,239	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,273,894		1,273,894		1,273,894	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,519,808	0	56,519,808	9,297	56,529,105	200.00
201.00		Less Observation Beds	1,006,239		1,006,239		1,006,239	201.00
202.00		Total (see instructions)	55,513,569	0	55,513,569	9,297	55,522,866	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		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	9,771,665		9,771,665			30.00
31.00	03100	INTENSIVE CARE UNIT	1,899,932		1,899,932			31.00
41.00	04100	SUBPROVIDER - IRF	1,689,367		1,689,367			41.00
43.00	04300	NURSERY	588,823		588,823			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,425,087	21,777,376	27,202,463	0.249390	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	605,252	1,894,783	2,500,035	0.058569	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,022,060	29,725,467	33,747,527	0.178055	0.000000	54.00
60.00	06000	LABORATORY	5,839,512	18,981,458	24,820,970	0.215697	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,177,197	2,324,388	5,501,585	0.329848	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,157,305	2,028,790	3,186,095	0.446091	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,138,265	588,959	1,727,224	0.227841	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	264,311	283,969	548,280	0.391285	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,398,606	3,786,651	5,185,257	0.244625	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,498	102,831	177,329	0.560128	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,019,771	2,972,267	5,992,038	0.467272	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,300	4,245,986	4,247,286	0.380646	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,233,894	8,473,272	12,707,166	0.421393	0.000000	73.00
76.00	03020	ONCOLOGY	9,119	1,000,162	1,009,281	0.607994	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	968	338,339	339,307	0.691451	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,348	7,813,521	7,834,869	0.452563	0.000000	90.00
91.00	09100	EMERGENCY	2,683,572	14,281,901	16,965,473	0.250880	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	486,244	1,067,119	1,553,363	0.647781	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,396,476	1,396,476			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	47,508,096	123,083,715	170,591,811			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	47,508,096	123,083,715	170,591,811			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.249688	50.00
53.00	05300	ANESTHESIOLOGY	0.058569	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178055	54.00
60.00	06000	LABORATORY	0.215697	60.00
65.00	06500	RESPIRATORY THERAPY	0.329848	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227841	67.00
68.00	06800	SPEECH PATHOLOGY	0.391285	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244625	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.560128	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.467272	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380646	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421393	73.00
76.00	03020	ONCOLOGY	0.607994	76.00
76.97	07697	CARDIAC REHABILITATION	0.691451	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.452563	90.00
91.00	09100	EMERGENCY	0.250880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.647781	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 1:29 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,328,932		7,328,932	0	7,328,932	30.00
31.00	03100	INTENSIVE CARE UNIT	2,703,735		2,703,735	0	2,703,735	31.00
41.00	04100	SUBPROVIDER - IRF	1,847,955		1,847,955	1,196	1,849,151	41.00
43.00	04300	NURSERY	432,430		432,430	0	432,430	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,784,018		6,784,018	8,101	6,792,119	50.00
53.00	05300	ANESTHESIOLOGY	146,425		146,425	0	146,425	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,008,905		6,008,905	0	6,008,905	54.00
60.00	06000	LABORATORY	5,353,812		5,353,812	0	5,353,812	60.00
65.00	06500	RESPIRATORY THERAPY	1,814,688	0	1,814,688	0	1,814,688	65.00
66.00	06600	PHYSICAL THERAPY	1,421,288	0	1,421,288	0	1,421,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	393,533	0	393,533	0	393,533	67.00
68.00	06800	SPEECH PATHOLOGY	214,534	0	214,534	0	214,534	68.00
69.00	06900	ELECTROCARDIOLOGY	1,268,444		1,268,444	0	1,268,444	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	99,327		99,327	0	99,327	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,799,913		2,799,913	0	2,799,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,616,712		1,616,712	0	1,616,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,354,708		5,354,708	0	5,354,708	73.00
76.00	03020	ONCOLOGY	613,637		613,637	0	613,637	76.00
76.97	07697	CARDIAC REHABILITATION	234,614		234,614	0	234,614	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,545,775		3,545,775	0	3,545,775	90.00
91.00	09100	EMERGENCY	4,256,290		4,256,290	0	4,256,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,006,239		1,006,239		1,006,239	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,273,894		1,273,894		1,273,894	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,519,808	0	56,519,808	9,297	56,529,105	200.00
201.00		Less Observation Beds	1,006,239		1,006,239		1,006,239	201.00
202.00		Total (see instructions)	55,513,569	0	55,513,569	9,297	55,522,866	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 1:29 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	9,771,665		9,771,665			30.00
31.00	03100	INTENSIVE CARE UNIT	1,899,932		1,899,932			31.00
41.00	04100	SUBPROVIDER - IRF	1,689,367		1,689,367			41.00
43.00	04300	NURSERY	588,823		588,823			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,425,087	21,777,376	27,202,463	0.249390	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	605,252	1,894,783	2,500,035	0.058569	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,022,060	29,725,467	33,747,527	0.178055	0.000000	54.00
60.00	06000	LABORATORY	5,839,512	18,981,458	24,820,970	0.215697	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,177,197	2,324,388	5,501,585	0.329848	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,157,305	2,028,790	3,186,095	0.446091	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,138,265	588,959	1,727,224	0.227841	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	264,311	283,969	548,280	0.391285	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,398,606	3,786,651	5,185,257	0.244625	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,498	102,831	177,329	0.560128	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,019,771	2,972,267	5,992,038	0.467272	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,300	4,245,986	4,247,286	0.380646	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,233,894	8,473,272	12,707,166	0.421393	0.000000	73.00
76.00	03020	ONCOLOGY	9,119	1,000,162	1,009,281	0.607994	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	968	338,339	339,307	0.691451	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,348	7,813,521	7,834,869	0.452563	0.000000	90.00
91.00	09100	EMERGENCY	2,683,572	14,281,901	16,965,473	0.250880	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	486,244	1,067,119	1,553,363	0.647781	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,396,476	1,396,476			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	47,508,096	123,083,715	170,591,811			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	47,508,096	123,083,715	170,591,811			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 1:29 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
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	ONCOLOGY	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	672,796	0	672,796	7,065	95.23	30.00
31.00	INTENSIVE CARE UNIT	230,414		230,414	1,026	224.58	31.00
41.00	SUBPROVIDER - IRF	134,859	0	134,859	1,447	93.20	41.00
43.00	NURSERY	17,039		17,039	707	24.10	43.00
200.00	Total (lines 30-199)	1,055,108		1,055,108	10,245		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,283	312,640				30.00
31.00	INTENSIVE CARE UNIT	267	59,963				31.00
41.00	SUBPROVIDER - IRF	702	65,426				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	4,252	438,029				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,010,298	27,202,463	0.037140	2,147,260	79,749	50.00
53.00	05300	ANESTHESIOLOGY	38,599	2,500,035	0.015439	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	565,123	33,747,527	0.016746	2,070,791	34,677	54.00
60.00	06000	LABORATORY	300,530	24,820,970	0.012108	3,186,693	38,584	60.00
65.00	06500	RESPIRATORY THERAPY	109,566	5,501,585	0.019915	1,300,716	25,904	65.00
66.00	06600	PHYSICAL THERAPY	81,466	3,186,095	0.025569	319,859	8,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,077	1,727,224	0.011045	293,283	3,239	67.00
68.00	06800	SPEECH PATHOLOGY	5,678	548,280	0.010356	74,916	776	68.00
69.00	06900	ELECTROCARDIOLOGY	114,822	5,185,257	0.022144	969,701	21,473	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,186	177,329	0.046163	3,200	148	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	111,370	5,992,038	0.018586	1,829,949	34,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,463	4,247,286	0.003170	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,696	12,707,166	0.005642	2,260,371	12,753	73.00
76.00	03020	ONCOLOGY	76,051	1,009,281	0.075352	1,783	134	76.00
76.97	07697	CARDIAC REHABILITATION	23,495	339,307	0.069244	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	194,324	7,834,869	0.024802	19,453	482	90.00
91.00	09100	EMERGENCY	268,272	16,965,473	0.015813	1,186,017	18,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92,373	1,553,363	0.059466	0	0	92.00
200.00		Total (lines 50-199)	3,104,389	155,245,548		15,663,992	278,862	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,065	0.00	3,283	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,026	0.00	267	0		31.00
41.00	04100	SUBPROVIDER - IRF	1,447	0.00	702	0		41.00
43.00	04300	NURSERY	707	0.00	0	0		43.00
200.00		Total (lines 30-199)	10,245		4,252	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,202,463	0.000000	0.000000	2,147,260	50.00
53.00	05300	ANESTHESIOLOGY	0	2,500,035	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,747,527	0.000000	0.000000	2,070,791	54.00
60.00	06000	LABORATORY	0	24,820,970	0.000000	0.000000	3,186,693	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,501,585	0.000000	0.000000	1,300,716	65.00
66.00	06600	PHYSICAL THERAPY	0	3,186,095	0.000000	0.000000	319,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,727,224	0.000000	0.000000	293,283	67.00
68.00	06800	SPEECH PATHOLOGY	0	548,280	0.000000	0.000000	74,916	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,185,257	0.000000	0.000000	969,701	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	177,329	0.000000	0.000000	3,200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,992,038	0.000000	0.000000	1,829,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,247,286	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,707,166	0.000000	0.000000	2,260,371	73.00
76.00	03020	ONCOLOGY	0	1,009,281	0.000000	0.000000	1,783	76.00
76.97	07697	CARDIAC REHABILITATION	0	339,307	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,834,869	0.000000	0.000000	19,453	90.00
91.00	09100	EMERGENCY	0	16,965,473	0.000000	0.000000	1,186,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,553,363	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	155,245,548			15,663,992	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,725,030	0		50.00
53.00	05300	ANESTHESIOLOGY	0	775,923	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,572,516	0		54.00
60.00	06000	LABORATORY	0	1,567,044	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	142,751	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	600	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	372	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,042,485	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	913,133	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	954,153	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,839,880	0		73.00
76.00	03020	ONCOLOGY	0	137,832	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	107,310	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	2,348,336	0		90.00
91.00	09100	EMERGENCY	0	2,481,533	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	27,608,898	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		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	0.249390	4,725,030	0	0	1,178,375	50.00
53.00	05300	ANESTHESIOLOGY	0.058569	775,923	0	0	45,445	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178055	7,572,516	0	0	1,348,324	54.00
60.00	06000	LABORATORY	0.215697	1,567,044	0	0	338,007	60.00
65.00	06500	RESPIRATORY THERAPY	0.329848	142,751	0	0	47,086	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227841	600	0	0	137	67.00
68.00	06800	SPEECH PATHOLOGY	0.391285	372	0	0	146	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244625	2,042,485	0	0	499,643	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.560128	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.467272	913,133	0	0	426,681	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380646	954,153	0	0	363,195	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421393	3,839,880	0	2,479	1,618,099	73.00
76.00	03020	ONCOLOGY	0.607994	137,832	0	0	83,801	76.00
76.97	07697	CARDIAC REHABILITATION	0.691451	107,310	0	0	74,200	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.452563	2,348,336	96	0	1,062,770	90.00
91.00	09100	EMERGENCY	0.250880	2,481,533	0	0	622,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.647781	0	0	0	0	92.00
200.00		Subtotal (see instructions)		27,608,898	96	2,479	7,708,476	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		27,608,898	96	2,479	7,708,476	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,045		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	43	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	43	1,045		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	43	1,045		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,010,298	27,202,463	0.037140	7,609	283	50.00
53.00	05300	ANESTHESIOLOGY	38,599	2,500,035	0.015439	4,020	62	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	565,123	33,747,527	0.016746	30,289	507	54.00
60.00	06000	LABORATORY	300,530	24,820,970	0.012108	116,777	1,414	60.00
65.00	06500	RESPIRATORY THERAPY	109,566	5,501,585	0.019915	68,804	1,370	65.00
66.00	06600	PHYSICAL THERAPY	81,466	3,186,095	0.025569	319,129	8,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,077	1,727,224	0.011045	334,709	3,697	67.00
68.00	06800	SPEECH PATHOLOGY	5,678	548,280	0.010356	81,356	843	68.00
69.00	06900	ELECTROCARDIOLOGY	114,822	5,185,257	0.022144	14,614	324	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,186	177,329	0.046163	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	111,370	5,992,038	0.018586	32,546	605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,463	4,247,286	0.003170	1,267	4	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,696	12,707,166	0.005642	85,836	484	73.00
76.00	03020	ONCOLOGY	76,051	1,009,281	0.075352	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	23,495	339,307	0.069244	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	194,324	7,834,869	0.024802	0	0	90.00
91.00	09100	EMERGENCY	268,272	16,965,473	0.015813	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,553,363	0.000000	0	0	92.00
200.00		Total (lines 50-199)	3,012,016	155,245,548		1,096,956	17,753	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,202,463	0.000000	0.000000	7,609	50.00
53.00	05300	ANESTHESIOLOGY	0	2,500,035	0.000000	0.000000	4,020	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,747,527	0.000000	0.000000	30,289	54.00
60.00	06000	LABORATORY	0	24,820,970	0.000000	0.000000	116,777	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,501,585	0.000000	0.000000	68,804	65.00
66.00	06600	PHYSICAL THERAPY	0	3,186,095	0.000000	0.000000	319,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,727,224	0.000000	0.000000	334,709	67.00
68.00	06800	SPEECH PATHOLOGY	0	548,280	0.000000	0.000000	81,356	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,185,257	0.000000	0.000000	14,614	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	177,329	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,992,038	0.000000	0.000000	32,546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,247,286	0.000000	0.000000	1,267	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,707,166	0.000000	0.000000	85,836	73.00
76.00	03020	ONCOLOGY	0	1,009,281	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	339,307	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,834,869	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	16,965,473	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,553,363	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	155,245,548			1,096,956	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	ONCOLOGY	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	90	0		90.00
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)	0	90	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

		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	0.249390	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.058569	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178055	0	0	0	0	54.00
60.00	06000	LABORATORY	0.215697	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.329848	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227841	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.391285	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244625	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.560128	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.467272	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380646	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421393	0	0	223	0	73.00
76.00	03020	ONCOLOGY	0.607994	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.691451	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.452563	90	0	0	41	90.00
91.00	09100	EMERGENCY	0.250880	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.647781	0	0	0	0	92.00
200.00		Subtotal (see instructions)		90	0	223	41	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		90	0	223	41	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

		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
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	94		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	94		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	94		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 1:29 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	0.249390	0	1,080,881	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.058569	0	108,067	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178055	0	1,328,924	0	0	54.00
60.00	06000	LABORATORY	0.215697	0	734,528	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.329848	0	92,932	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	0	54,428	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227841	0	68,715	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.391285	0	50,126	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244625	0	77,049	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.560128	0	6,073	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.467272	0	412,686	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380646	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421393	0	376,025	0	0	73.00
76.00	03020	ONCOLOGY	0.607994	0	20,795	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.691451	0	3,485	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.452563	0	73,039	0	0	90.00
91.00	09100	EMERGENCY	0.250880	0	1,240,245	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.647781	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	5,727,998	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	5,727,998	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 1:29 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	269,561	0		50.00
53.00	05300	ANESTHESIOLOGY	6,329	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	236,622	0		54.00
60.00	06000	LABORATORY	158,435	0		60.00
65.00	06500	RESPIRATORY THERAPY	30,653	0		65.00
66.00	06600	PHYSICAL THERAPY	24,280	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	15,656	0		67.00
68.00	06800	SPEECH PATHOLOGY	19,614	0		68.00
69.00	06900	ELECTROCARDIOLOGY	18,848	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,402	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	192,837	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,454	0		73.00
76.00	03020	ONCOLOGY	12,643	0		76.00
76.97	07697	CARDIAC REHABILITATION	2,410	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	33,055	0		90.00
91.00	09100	EMERGENCY	311,153	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	1,493,952	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,493,952	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,065	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,065	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)	6,095	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,283	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,328,932	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)	7,328,932	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)	7,328,932	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)	1,037.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,405,653	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,405,653	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,703,735	1,026	2,635.22	267	703,604	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)	4,614,111	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,723,368	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)	372,603	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	278,862	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	651,465	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,071,903	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)	970	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,037.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,006,239	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	672,796	7,328,932	0.091800	1,006,239	92,373	90.00
91.00	Nursing School cost	0	7,328,932	0.000000	1,006,239	0	91.00
92.00	Allied health cost	0	7,328,932	0.000000	1,006,239	0	92.00
93.00	All other Medical Education	0	7,328,932	0.000000	1,006,239	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/21/2015 1:29 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,447	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,447	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,447	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	702	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,849,151	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)	1,849,151	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)	1,849,151	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)	1,277.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	897,100	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)	897,100	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	361,301	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,258,401	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)	65,426	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,753	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	83,179	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,175,222	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	134,859	1,849,151	0.072930	0	0	90.00
91.00	Nursing School cost	0	1,849,151	0.000000	0	0	91.00
92.00	Allied health cost	0	1,849,151	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,849,151	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,065	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,065	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)	6,095	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	303	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)	707	15.00
16.00	Nursery days (title V or XIX only)	35	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,328,932	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)	7,328,932	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)	7,328,932	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)	1,037.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	314,320	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)	314,320	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 1:29 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)	432,430	707	611.64	35	21,407	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,703,735	1,026	2,635.22	50	131,761	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)	420,284	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	887,772	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)	970	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,037.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,006,239	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 1:29 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	672,796	7,328,932	0.091800	1,006,239	92,373	90.00
91.00	Nursing School cost	0	7,328,932	0.000000	1,006,239	0	91.00
92.00	Allied health cost	0	7,328,932	0.000000	1,006,239	0	92.00
93.00	All other Medical Education	0	7,328,932	0.000000	1,006,239	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/21/2015 1:29 pm
	Title XIX	Subprovider - IRF	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)	1,447	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,447	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,447	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	175	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)	707	15.00
16.00	Nursery days (title V or XIX only)	35	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,847,955	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)	1,847,955	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)	1,847,955	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)	1,277.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	223,491	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)	223,491	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XIX | Subprovider - IRF | 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	21,895	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	245,386	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 15T001 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XIX | Subprovider - IRF | 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	134,859	1,847,955	0.072977	0	0	90.00
91.00	Nursing School cost	0	1,847,955	0.000000	0	0	91.00
92.00	Allied health cost	0	1,847,955	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,847,955	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,326,965		30.00
31.00	03100	INTENSIVE CARE UNIT		515,196		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.249688	2,147,260	536,145	50.00
53.00	05300	ANESTHESIOLOGY	0.058569	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178055	2,070,791	368,715	54.00
60.00	06000	LABORATORY	0.215697	3,186,693	687,360	60.00
65.00	06500	RESPIRATORY THERAPY	0.329848	1,300,716	429,039	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	319,859	142,686	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227841	293,283	66,822	67.00
68.00	06800	SPEECH PATHOLOGY	0.391285	74,916	29,314	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244625	969,701	237,213	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.560128	3,200	1,792	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.467272	1,829,949	855,084	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380646	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421393	2,260,371	952,505	73.00
76.00	03020	ONCOLOGY	0.607994	1,783	1,084	76.00
76.97	07697	CARDIAC REHABILITATION	0.691451	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.452563	19,453	8,804	90.00
91.00	09100	EMERGENCY	0.250880	1,186,017	297,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.647781	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		15,663,992	4,614,111	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)		15,663,992		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		799,455		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.249688	7,609	1,900	50.00
53.00	05300	ANESTHESIOLOGY	0.058569	4,020	235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178055	30,289	5,393	54.00
60.00	06000	LABORATORY	0.215697	116,777	25,188	60.00
65.00	06500	RESPIRATORY THERAPY	0.329848	68,804	22,695	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	319,129	142,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227841	334,709	76,260	67.00
68.00	06800	SPEECH PATHOLOGY	0.391285	81,356	31,833	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244625	14,614	3,575	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.560128	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.467272	32,546	15,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380646	1,267	482	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421393	85,836	36,171	73.00
76.00	03020	ONCOLOGY	0.607994	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.691451	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.452563	0	0	90.00
91.00	09100	EMERGENCY	0.250880	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.647781	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,096,956	361,301	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,096,956		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 1:29 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		784,887		30.00
31.00	03100	INTENSIVE CARE UNIT		50,260		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		186,587		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.249390	380,948	95,005	50.00
53.00	05300	ANESTHESIOLOGY	0.058569	52,886	3,097	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178055	132,044	23,511	54.00
60.00	06000	LABORATORY	0.215697	276,599	59,662	60.00
65.00	06500	RESPIRATORY THERAPY	0.329848	120,009	39,585	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	9,226	4,116	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227841	8,604	1,960	67.00
68.00	06800	SPEECH PATHOLOGY	0.391285	1,971	771	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244625	15,529	3,799	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.560128	1,426	799	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.467272	159,386	74,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380646	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421393	217,007	91,445	73.00
76.00	03020	ONCOLOGY	0.607994	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.691451	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.452563	697	315	90.00
91.00	09100	EMERGENCY	0.250880	86,662	21,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.647781	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,462,994	420,284	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,462,994		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 1:29 pm

Title XIX | Subprovider - IRF | 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
41.00	04100	SUBPROVIDER - IRF		58,044		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.249390	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.058569	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178055	1,400	249	54.00
60.00	06000	LABORATORY	0.215697	6,718	1,449	60.00
65.00	06500	RESPIRATORY THERAPY	0.329848	4,072	1,343	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	25,325	11,297	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227841	26,160	5,960	67.00
68.00	06800	SPEECH PATHOLOGY	0.391285	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244625	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.560128	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.467272	178	83	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.380646	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.421393	3,593	1,514	73.00
76.00	03020	ONCOLOGY	0.607994	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.691451	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.452563	0	0	90.00
91.00	09100	EMERGENCY	0.250880	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.647781	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		67,446	21,895	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)		67,446		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		4,212,316		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,424,467		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		59,789		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		1,349,172		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		83.34		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.11		30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.48		31.00
32.00	Sum of lines 30 and 31		20.59		32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.20		33.00
34.00	Disproportionate share adjustment (see instructions)		87,370		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000061598	0.000045337	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		557,239	346,723	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		416,784	87,393	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		504,177		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		6,288,119		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		6,288,119		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		454,863		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,742,982		59.00
60.00	Primary payer payments		9,233		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,733,749		61.00
62.00	Deductibles billed to program beneficiaries		792,512		62.00
63.00	Coinsurance billed to program beneficiaries		8,816		63.00
64.00	Allowable bad debts (see instructions)		43,508		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		28,280		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		-24,085		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,960,701		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-10,828		70.93
70.94	HRR adjustment amount (see instructions)		-2,279		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/21/2015 1:29 pm
	Title XVIII	Hospital	PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,947,594		71.00
71.01	Sequestration adjustment (see instructions)		118,952		71.01
72.00	Interim payments		5,794,175		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		34,467		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		38,611		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,212,316	0	4,212,316	0	4,212,316	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,424,467	0	0	1,424,467	1,424,467	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	59,789	0	59,789	0	59,789	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,349,172	0	1,041,433	307,739	1,349,172	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0620	0.0620	0.0620	0.0620		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	87,370	0	65,291	22,079	87,370	11.00
11.01	Uncompensated care payments	36.00	504,177	0	416,784	87,493	504,277	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,288,119	0	4,754,080	1,534,039	6,288,119	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,288,119	0	4,754,080	1,534,039	6,288,119	15.00
16.00	Payment for inpatient program capital	50.00	454,863	0	340,924	113,939	454,863	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	5,095,004	1,647,978	6,742,982	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	450,637	0	336,698	113,939	450,637	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,226	0	4,226	0	4,226	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	454,863	0	340,924	113,939	454,863	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.087500	0.076607		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			445,813		445,813	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				126,247	126,247	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,212,316	4,212,316		4,212,316	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,424,467		1,424,467	1,424,467	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	59,789	0	59,789	59,789	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,349,172	1,041,433	307,739	1,349,172	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0620	0.0620	0.0620		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	87,370	65,291	22,079	87,370	11.00
11.01	Uncompensated care payments	36.00	504,177	416,784	87,393	504,177	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,288,119	4,694,391	1,593,728	6,288,119	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,288,119	4,694,391	1,593,728	6,288,119	15.00
16.00	Payment for inpatient program capital	50.00	454,863	3,161	451,702	454,863	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,697,552	2,045,430	6,742,982	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	450,637	0	450,637	450,637	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,226	3,161	1,065	4,226	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	454,863	3,161	451,702	454,863	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-10,828	-8,099	-2,729	-10,828	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-2,279	-1,705	-574	-2,279	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/21/2015 1:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,088	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,708,476	2.00
3.00	PPS payments	6,428,895	3.00
4.00	Outlier payment (see instructions)	39,271	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)	1,088	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,575	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)	2,575	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)	2,575	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,487	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)	1,088	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)	6,468,166	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,409,778	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)	5,059,476	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)	5,059,476	30.00
31.00	Primary payer payments	2,018	31.00
32.00	Subtotal (line 30 minus line 31)	5,057,458	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)	157,893	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	102,630	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	72,329	36.00
37.00	Subtotal (see instructions)	5,160,088	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-27	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,160,115	40.00
40.01	Sequestration adjustment (see instructions)	103,202	40.01
41.00	Interim payments	5,132,929	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-76,016	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/21/2015 1:29 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	94	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	41	2.00
3.00	PPS payments	117	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)	94	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	223	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)	223	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)	223	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	129	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)	94	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)	117	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	211	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)	211	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	211	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	211	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)	211	40.00
40.01	Sequestration adjustment (see instructions)	4	40.01
41.00	Interim payments	210	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-3	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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,794,175		5,132,929	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)		5,794,175		5,132,929	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		34,467		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		76,016	6.02
7.00	Total Medicare program liability (see instructions)		5,828,642		5,056,913	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: 150001 | Component CCN: 15T001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2015 1:29 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		971,086		210	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)		971,086		210	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		26,707		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		3	6.02
7.00	Total Medicare program liability (see instructions)		997,793		207	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: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/21/2015 1:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,186	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,550	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	956	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	7,121	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	170,591,811	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	9,725,962	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	740,583	8.00
9.00	Sequestration adjustment amount (see instructions)	14,812	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	725,771	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	713,032	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)	12,739	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/21/2015 1:29 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	972,667	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0322	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	52,329	3.00
4.00	Outlier Payments	8,479	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	3.964384	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,033,475	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,033,475	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,033,475	19.00
20.00	Deductibles	10,944	20.00
21.00	Subtotal (line 19 minus line 20)	1,022,531	21.00
22.00	Coinsurance	4,864	22.00
23.00	Subtotal (line 21 minus line 22)	1,017,667	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	753	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	489	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	390	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,018,156	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,018,156	32.00
32.01	Sequestration adjustment (see instructions)	20,363	32.01
33.00	Interim payments	971,086	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	26,707	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	8,479	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-3 Part VII | Date/Time Prepared: 5/21/2015 1:29 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	887,772		1.00
2.00	Medical and other services		1,493,952	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	887,772	1,493,952	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)	887,772	1,493,952	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,265,109		8.00
9.00	Ancillary service charges	1,462,994	5,727,998	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)	2,728,103	5,727,998	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)	2,728,103	5,727,998	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,840,331	4,234,046	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)	887,772	1,493,952	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)	887,772	1,493,952	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)	887,772	1,493,952	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)	887,772	1,493,952	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	887,772	1,493,952	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)	887,772	1,493,952	40.00
41.00	Interim payments	837,280	1,392,260	41.00
42.00	Balance due provider/program (line 40 minus line 41)	50,492	101,692	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/21/2015 1:29 pm
	Title XIX	Subprovider - IRF	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	245,386		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	245,386	0	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)	245,386	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	63,437		8.00
9.00	Ancillary service charges	67,446	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	130,883	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	130,883	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	114,503	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)	130,883	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		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)	130,883	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	114,503	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	130,883	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	130,883	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	130,883	0	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)	130,883	0	40.00
41.00	Interim payments	130,883	0	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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/21/2015 1:29 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	3,713,129	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,230,423	0	0	0	4.00
5.00	Other receivable	6,792,085	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,194,905	0	0	0	6.00
7.00	Inventory	1,460,066	0	0	0	7.00
8.00	Prepaid expenses	1,395,368	0	0	0	8.00
9.00	Other current assets	10,010,598	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)	34,406,764	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,141,963	0	0	0	12.00
13.00	Land improvements	1,603,865	0	0	0	13.00
14.00	Accumulated depreciation	-1,063,901	0	0	0	14.00
15.00	Buildings	66,154,520	0	0	0	15.00
16.00	Accumulated depreciation	-36,337,082	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	11,690,283	0	0	0	19.00
20.00	Accumulated depreciation	-9,355,643	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	36,227,029	0	0	0	23.00
24.00	Accumulated depreciation	-28,224,859	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	2,584,230	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	46,420,405	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	45,472,986	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	71,375	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	45,544,361	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	126,371,530	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,655,344	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	71,097	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	4,120,988	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,847,429	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	5,847,429	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	120,524,101				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)	120,524,101	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	126,371,530	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/21/2015 1:29 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		99,426,899		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		553,972				2.00
3.00	Total (sum of line 1 and line 2)		99,980,871		0		3.00
4.00	TRANSFER FROM OTHER FUNDS	20,534,214		0		0	4.00
5.00	OTHER ADJUSTMENT	9,016		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)		20,543,230		0		10.00
11.00	Subtotal (line 3 plus line 10)		120,524,101		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)		120,524,101		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	TRANSFER FROM OTHER FUNDS		0			4.00
5.00	OTHER ADJUSTMENT		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: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/21/2015 1:29 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,616,596		11,616,596	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,689,367		1,689,367	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)	13,305,963		13,305,963	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,197,658		2,197,658	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)	2,197,658		2,197,658	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,503,621		15,503,621	17.00
18.00	Ancillary services	33,174,447	99,296,045	132,470,492	18.00
19.00	Outpatient services	0	21,791,432	21,791,432	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		1,396,476	1,396,476	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 REVENUE	0	9,036,873	9,036,873	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	48,678,068	131,520,826	180,198,894	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		76,221,831		29.00
30.00	LOSS ON SALE OF ASSET	45,431			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)		45,431		36.00
37.00	FISCAL SERVICES EXPENSES	1,200,000			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)		1,200,000		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		75,067,262		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/21/2015 1:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	180,198,894	1.00
2.00	Less contractual allowances and discounts on patients' accounts	107,202,115	2.00
3.00	Net patient revenues (line 1 minus line 2)	72,996,779	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	75,067,262	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,070,483	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	300,019	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 OPERATING REVENUE	1,785,223	24.00
24.01	OTHER NON-OPERATING REVENUE	26,310	24.01
24.02	RENTAL REVENUE	512,903	24.02
25.00	Total other income (sum of lines 6-24)	2,624,455	25.00
26.00	Total (line 5 plus line 25)	553,972	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)	553,972	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150001 | HHA CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H | Date/Time Prepared: 5/21/2015 1:29 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	172,799	0	58,297	0	101,773	332,869	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	294,864	0	0	0	0	294,864	6.00
7.00	Physical Therapy	95,144	0	0	0	0	95,144	7.00
8.00	Occupational Therapy	72,641	0	0	0	0	72,641	8.00
9.00	Speech Pathology	408	0	0	0	0	408	9.00
10.00	Medical Social Services	684	0	0	0	0	684	10.00
11.00	Home Health Aide	4,997	0	0	0	0	4,997	11.00
12.00	Supplies (see instructions)	0	0	0	0	8,036	8,036	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	641,537	0	58,297	0	109,809	809,643	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	332,869	0	332,869			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	294,864	0	294,864			6.00
7.00	Physical Therapy	0	95,144	0	95,144			7.00
8.00	Occupational Therapy	0	72,641	0	72,641			8.00
9.00	Speech Pathology	0	408	0	408			9.00
10.00	Medical Social Services	0	684	0	684			10.00
11.00	Home Health Aide	0	4,997	0	4,997			11.00
12.00	Supplies (see instructions)	0	8,036	0	8,036			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	809,643	0	809,643			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 150001 | HHA CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part I | Date/Time Prepared: 5/21/2015 1:29 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	332,869	0	0	0	0	332,869	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	294,864	0	0	0	0	294,864	6.00
7.00	Physical Therapy	95,144	0	0	0	0	95,144	7.00
8.00	Occupational Therapy	72,641	0	0	0	0	72,641	8.00
9.00	Speech Pathology	408	0	0	0	0	408	9.00
10.00	Medical Social Services	684	0	0	0	0	684	10.00
11.00	Home Health Aide	4,997	0	0	0	0	4,997	11.00
12.00	Supplies (see instructions)	8,036	0	0	0	0	8,036	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	809,643	0	0	0	0	809,643	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	332,869		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	205,864	500,728	6.00
7.00	Physical Therapy	66,427	161,571	7.00
8.00	Occupational Therapy	50,716	123,357	8.00
9.00	Speech Pathology	285	693	9.00
10.00	Medical Social Services	478	1,162	10.00
11.00	Home Health Aide	3,489	8,486	11.00
12.00	Supplies (see instructions)	5,610	13,646	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		809,643	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 150001 | HHA CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part II Date/Time Prepared: 5/21/2015 1:29 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-332,869	476,774	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	294,864	6.00
7.00	Physical Therapy	0	0	0	0	0	95,144	7.00
8.00	Occupational Therapy	0	0	0	0	0	72,641	8.00
9.00	Speech Pathology	0	0	0	0	0	408	9.00
10.00	Medical Social Services	0	0	0	0	0	684	10.00
11.00	Home Health Aide	0	0	0	0	0	4,997	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	8,036	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-332,869	476,774	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		332,869	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.698169	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I

HHA CCN: 157510 | Date/Time Prepared: 5/21/2015 1:29 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS					
			BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		0	1.00	1.01	2.00	4.00	4.01	
1.00	Administrative and General	0	8,354	0	963	43,676	8,021	1.00
2.00	Skilled Nursing Care	500,728	0	0	0	74,529	0	2.00
3.00	Physical Therapy	161,571	0	0	0	24,048	0	3.00
4.00	Occupational Therapy	123,357	0	0	0	18,361	0	4.00
5.00	Speech Pathology	693	0	0	0	103	0	5.00
6.00	Medical Social Services	1,162	0	0	0	173	0	6.00
7.00	Home Health Aide	8,486	0	0	0	1,263	0	7.00
8.00	Supplies (see instructions)	13,646	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	809,643	8,354	0	963	162,153	8,021	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	DATA PROCESSING	MATERIALS MANAGEMENT	ADMITTING	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	
		4.02	4.03	4.04	4.05	4A.05	5.00	
1.00	Administrative and General	46,300	880	7,616	16,920	132,730	19,577	1.00
2.00	Skilled Nursing Care	0	0	0	0	575,257	84,846	2.00
3.00	Physical Therapy	0	0	0	0	185,619	27,377	3.00
4.00	Occupational Therapy	0	0	0	0	141,718	20,902	4.00
5.00	Speech Pathology	0	0	0	0	796	117	5.00
6.00	Medical Social Services	0	0	0	0	1,335	197	6.00
7.00	Home Health Aide	0	0	0	0	9,749	1,438	7.00
8.00	Supplies (see instructions)	0	0	0	0	13,646	2,013	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	46,300	880	7,616	16,920	1,060,850	156,467	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150001 | HHA CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/21/2015 1:29 pm

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	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	21,960	0	6,884	0	16,757	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	21,960	0	6,884	0	16,757	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	10,976	208,884	0	208,884	1.00
2.00	Skilled Nursing Care	0	0	0	660,103	0	660,103	2.00
3.00	Physical Therapy	0	0	0	212,996	0	212,996	3.00
4.00	Occupational Therapy	0	0	0	162,620	0	162,620	4.00
5.00	Speech Pathology	0	0	0	913	0	913	5.00
6.00	Medical Social Services	0	0	0	1,532	0	1,532	6.00
7.00	Home Health Aide	0	0	0	11,187	0	11,187	7.00
8.00	Supplies (see instructions)	0	0	0	15,659	0	15,659	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	10,976	1,273,894	0	1,273,894	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150001 HHA CCN: 157510

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

Worksheet H-2 Part I Date/Time Prepared: 5/21/2015 1:29 pm

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs				
		27.00	28.00				
1.00	Administrative and General						1.00
2.00	Skilled Nursing Care	129,469	789,572				2.00
3.00	Physical Therapy	41,776	254,772				3.00
4.00	Occupational Therapy	31,895	194,515				4.00
5.00	Speech Pathology	179	1,092				5.00
6.00	Medical Social Services	300	1,832				6.00
7.00	Home Health Aide	2,194	13,381				7.00
8.00	Supplies (see instructions)	3,071	18,730				8.00
9.00	Drugs	0	0				9.00
10.00	DME	0	0				10.00
11.00	Home Dialysis Aide Services	0	0				11.00
12.00	Respiratory Therapy	0	0				12.00
13.00	Private Duty Nursing	0	0				13.00
14.00	Clinic	0	0				14.00
15.00	Health Promotion Activities	0	0				15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program	0	0				17.00
18.00	Homemaker Service	0	0				18.00
19.00	All Others (specify)	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	208,884	1,273,894				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.196133					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150001 HHA CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II Date/Time Prepared: 5/21/2015 1:29 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (TOTAL FEET)	CAPITAL RELATED COSTS BLDG & FIXT - TOWER (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
		1.00	1.01	2.00	4.00	4.01	4.02	
1.00	Administrative and General	1,305	0	868	172,799	21	44	1.00
2.00	Skilled Nursing Care	0	0	0	294,864	0	0	2.00
3.00	Physical Therapy	0	0	0	95,144	0	0	3.00
4.00	Occupational Therapy	0	0	0	72,641	0	0	4.00
5.00	Speech Pathology	0	0	0	408	0	0	5.00
6.00	Medical Social Services	0	0	0	684	0	0	6.00
7.00	Home Health Aide	0	0	0	4,997	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,305	0	868	641,537	21	44	20.00
21.00	Total cost to be allocated	8,354	0	963	162,153	8,021	46,300	21.00
22.00	Unit cost multiplier	6.401533	0.000000	1.109447	0.252757	381.952381	1,052.272727	22.00

	Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	
		4.03	4.04	4.05	5A	5.00	7.00	
1.00	Administrative and General	12,510	1,396,476	1,396,476	0	132,730	1,305	1.00
2.00	Skilled Nursing Care	0	0	0	0	575,257	0	2.00
3.00	Physical Therapy	0	0	0	0	185,619	0	3.00
4.00	Occupational Therapy	0	0	0	0	141,718	0	4.00
5.00	Speech Pathology	0	0	0	0	796	0	5.00
6.00	Medical Social Services	0	0	0	0	1,335	0	6.00
7.00	Home Health Aide	0	0	0	0	9,749	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	13,646	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	12,510	1,396,476	1,396,476		1,060,850	1,305	20.00
21.00	Total cost to be allocated	880	7,616	16,920		156,467	21,960	21.00
22.00	Unit cost multiplier	0.070344	0.005454	0.012116		0.147492	16.827586	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150001 HHA CCN: 157510

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

Worksheet H-2 Part II Date/Time Prepared: 5/21/2015 1:29 pm

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	1,305	0	22,431	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1,305	0	22,431	0	0	20.00
21.00	Total cost to be allocated	0	6,884	0	16,757	0	0	21.00
22.00	Unit cost multiplier	0.000000	5.275096	0.000000	0.747046	0.000000	0.000000	22.00

	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)					
		15.00	16.00					
1.00	Administrative and General	0	1,396,476					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19)	0	1,396,476					20.00
21.00	Total cost to be allocated	0	10,976					21.00
22.00	Unit cost multiplier	0.000000	0.007860					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 150001 | HHA CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/21/2015 1:29 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	789,572		789,572	2,753	286.80	1.00
2.00	Physical Therapy	3.00	254,772	0	254,772	1,840	138.46	2.00
3.00	Occupational Therapy	4.00	194,515	0	194,515	1,000	194.52	3.00
4.00	Speech Pathology	5.00	1,092	0	1,092	22	49.64	4.00
5.00	Medical Social Services	6.00	1,832		1,832	12	152.67	5.00
6.00	Home Health Aide	7.00	13,381		13,381	309	43.30	6.00
7.00	Total (sum of lines 1-6)		1,255,164	0	1,255,164	5,936		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	214			8.00
8.01	Skilled Nursing Care		26900	0	1,182			8.01
9.00	Physical Therapy		18020	0	102			9.00
9.01	Physical Therapy		26900	0	799			9.01
10.00	Occupational Therapy		18020	0	44			10.00
10.01	Occupational Therapy		26900	0	467			10.01
11.00	Speech Pathology		18020	0	0			11.00
11.01	Speech Pathology		26900	0	7			11.01
12.00	Medical Social Services		18020	0	0			12.00
12.01	Medical Social Services		26900	0	5			12.01
13.00	Home Health Aide		18020	0	16			13.00
13.01	Home Health Aide		26900	0	118			13.01
14.00	Total (sum of lines 8-13)			0	2,954			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	18,730	0	18,730	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,396		0	400,373		1.00
2.00	Physical Therapy	0	901		0	124,752		2.00
3.00	Occupational Therapy	0	511		0	99,400		3.00
4.00	Speech Pathology	0	7		0	347		4.00
5.00	Medical Social Services	0	5		0	763		5.00
6.00	Home Health Aide	0	134		0	5,802		6.00
7.00	Total (sum of lines 1-6)	0	2,954		0	631,437		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150001 HHA CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I Date/Time Prepared: 5/21/2015 1:29 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0				15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	400,373						1.00
2.00	Physical Therapy	124,752						2.00
3.00	Occupational Therapy	99,400						3.00
4.00	Speech Pathology	347						4.00
5.00	Medical Social Services	763						5.00
6.00	Home Health Aide	5,802						6.00
7.00	Total (sum of lines 1-6)	631,437						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150001 HHA CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II Date/Time Prepared: 5/21/2015 1:29 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.446091	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.227841	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.391285	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.467272	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.421393	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 150001 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II

HHA CCN: 157510 | Date/Time Prepared: 5/21/2015 1:29 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	548,281	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	1,799	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	550,080	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	550,080	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	550,080	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	550,080	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	550,080	31.00
31.01	Sequestration adjustment (see instructions)	0	11,002	31.01
32.00	Interim payments (see instructions)	0	539,078	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150001 | HHA CCN: 157510 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-5 | Date/Time Prepared: 5/21/2015 1:29 pm

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		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		0		539,078	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			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			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. H-4, Part II, column as appropriate, line 32)		0		539,078	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		539,078	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/21/2015 1:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	450,637	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	4,226	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	19.91	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	454,863	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00