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: 150166	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/27/2015 9:34 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/27/2015 Time: 9:34 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 PINNACLE HOSPITAL (150166) 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	0	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	0	0	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 9:33 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 9301 CONNECTICUT DRIVE	PO Box:			1.00
2.00	City: CROWN POINT	State: IN	Zip Code: 46307	County: LAKE	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	PINNACLE HOSPITAL	150166	23844	1	08/01/2007	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 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)	5		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 9:33 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 9:33 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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 9:33 pm

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

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

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

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

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

		Physical	Occupational	Speech	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.					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:	140,910	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 9:33 pm

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150166	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 9:33 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)			170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 9:33 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	07/30/2015	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.	Y			5.00

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	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)		Y	04/20/2015	Y	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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 9:33 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.	KARRIE	PENCE	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	816-751-1831	KARRIE.PENCE@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 9:33 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)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/20/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SUPERVISOR		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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 9:33 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	18	6,570	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)		18	6,570	0.00	0	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)		18	6,570	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					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)		18				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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 9:33 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,078	65	2,589			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,078	65	2,589			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)	1,078	65	2,589	0.00	150.05	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	150.05	27.00
28.00	Observation Bed Days		4	338			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 9:33 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	287	14	688	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	287	14	688	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2015 9:33 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	7,714,957	-724,746	6,990,211	312,097.00	22.40	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)		1,073,287	-36,967	1,036,320	31,424.00	32.98	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		247,451	0	247,451	3,755.00	65.90	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		0	0	0	0.00	0.00	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)		1,290,794	0	1,290,794			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		144,517	0	144,517			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	115,631	-24,851	90,780	2,072.00	43.81	26.00
27.00	Administrative & General	5.00	2,022,850	-242,234	1,780,616	61,940.00	28.75	27.00
28.00	Administrative & General under contract (see inst.)		106,410	0	106,410	531.00	200.40	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	41,886	-4,351	37,535	3,645.00	10.30	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	89,943	-9,303	80,640	7,915.00	10.19	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	167,220	-16,184	151,036	9,508.00	15.89	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/27/2015 9:33 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	
39.00	Central Services and Supply	14.00	169,489	-12,543	156,946	11,490.00	13.66	39.00
40.00	Pharmacy	15.00	364,324	-38,959	325,365	9,479.00	34.32	40.00
41.00	Medical Records & Medical Records Library	16.00	182,623	-15,263	167,360	9,071.00	18.45	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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/27/2015 9:33 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)		7,821,367	-724,746	7,096,621	312,628.00	22.70	1.00
2.00	Excluded area salaries (see instructions)		1,073,287	-36,967	1,036,320	31,424.00	32.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)		6,748,080	-687,779	6,060,301	281,204.00	21.55	3.00
4.00	Subtotal other wages & related costs (see inst.)		247,451	0	247,451	3,755.00	65.90	4.00
5.00	Subtotal wage-related costs (see inst.)		1,290,794	0	1,290,794	0.00	21.30	5.00
6.00	Total (sum of lines 3 thru 5)		8,286,325	-687,779	7,598,546	284,959.00	26.67	6.00
7.00	Total overhead cost (see instructions)		3,260,376	-363,688	2,896,688	115,651.00	25.05	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/27/2015 9:33 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	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	553,860	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	41,286	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	10,147	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)	34,011	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	402,593	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	393,415	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,435,312	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 5/27/2015 9:33 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	249,328	0	1.00
2.00	Hospital	249,328	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/27/2015 9:33 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)	0.278246	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	143,667	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	528,516	6.00
7.00	Medicaid cost (line 1 times line 6)	147,057	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)	3,390	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)	542,055	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	150,825	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)	150,825	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	154,215	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	0	0	0	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	0	0	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)	322,768	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	0	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	322,768	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	89,809	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	89,809	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	244,024	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 9:33 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		104,114	104,114	0	104,114	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,017,060	1,017,060	206,211	1,223,271	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	115,631	571,714	687,345	0	687,345	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,022,850	7,201,276	9,224,126	-193,455	9,030,671	5.00
7.00	00700	OPERATION OF PLANT	41,886	558,843	600,729	0	600,729	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	89,943	46,280	136,223	0	136,223	9.00
10.00	01000	DIETARY	167,220	82,537	249,757	0	249,757	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	169,489	182,818	352,307	0	352,307	14.00
15.00	01500	PHARMACY	364,324	12,628	376,952	0	376,952	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	182,623	66,312	248,935	0	248,935	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,359,727	35,442	1,395,169	0	1,395,169	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,156,746	28,353	1,185,099	-6,006	1,179,093	50.00
53.00	05300	ANESTHESIOLOGY	0	387,071	387,071	0	387,071	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	526,185	82,751	608,936	-6,750	602,186	54.00
60.00	06000	LABORATORY	0	65,385	65,385	0	65,385	60.00
65.00	06500	RESPIRATORY THERAPY	305,799	30,351	336,150	0	336,150	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,571,431	1,571,431	0	1,571,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,001,653	5,001,653	0	5,001,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	342,811	342,811	0	342,811	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	139,247	33,827	173,074	0	173,074	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,641,670	17,422,657	24,064,327	0	24,064,327	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,073,287	817,838	1,891,125	0	1,891,125	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	7,714,957	18,240,495	25,955,452	0	25,955,452	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 9:33 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	1,134,674	1,238,788		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,223,271		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,695	685,650		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,916,046	6,114,625		5.00
7.00	00700	OPERATION OF PLANT	-2,653	598,076		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	136,223		9.00
10.00	01000	DIETARY	0	249,757		10.00
11.00	01100	CAFETERIA	0	0		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	352,307		14.00
15.00	01500	PHARMACY	0	376,952		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,707	247,228		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,395,169		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,251	1,177,842		50.00
53.00	05300	ANESTHESIOLOGY	-387,064	7		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	602,186		54.00
60.00	06000	LABORATORY	0	65,385		60.00
65.00	06500	RESPIRATORY THERAPY	0	336,150		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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,571,431		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,001,653		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	342,811		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	URGENT CARE	0	173,074		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,175,742	21,888,585		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,891,125		192.00
194.00	07950	INDIANA BREAST CENTER	0	0		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,175,742	23,779,710		200.00

RECLASSIFICATIONS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 9:33 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - BENEFIT EXPENSE				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	24,851	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	242,234	2.00
3.00	OPERATION OF PLANT	7.00	0	4,351	3.00
4.00	HOUSEKEEPING	9.00	0	9,303	4.00
5.00	DIETARY	10.00	0	16,184	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,543	6.00
7.00	PHARMACY	15.00	0	38,959	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	15,263	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	175,101	9.00
10.00	OPERATING ROOM	50.00	0	59,692	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	49,383	11.00
12.00	RESPIRATORY THERAPY	65.00	0	27,392	12.00
13.00	URGENT CARE	90.01	0	12,523	13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	36,967	14.00
	0		0	724,746	
	B - CAPITAL INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	154,064	1.00
	0		0	154,064	
	C - RENTAL EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	52,147	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	52,147	
500.00	Grand Total: Increases		0	930,957	500.00

RECLASSIFICATIONS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 9:33 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - BENEFIT EXPENSE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	24,851	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	242,234	0	0	2.00
3.00	OPERATION OF PLANT	7.00	4,351	0	0	3.00
4.00	HOUSEKEEPING	9.00	9,303	0	0	4.00
5.00	DIETARY	10.00	16,184	0	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	12,543	0	0	6.00
7.00	PHARMACY	15.00	38,959	0	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	15,263	0	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	175,101	0	0	9.00
10.00	OPERATING ROOM	50.00	59,692	0	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	49,383	0	0	11.00
12.00	RESPIRATORY THERAPY	65.00	27,392	0	0	12.00
13.00	URGENT CARE	90.01	12,523	0	0	13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	36,967	0	0	14.00
	0		724,746	0		
	B - CAPITAL INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	154,064	11	1.00
	0		0	154,064		
	C - RENTAL EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,391	10	1.00
2.00	OPERATING ROOM	50.00	0	6,006	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,750	0	3.00
	0		0	52,147		
500.00	Grand Total: Decreases		724,746	206,211		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2015 9:33 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	25,000	0	0	0	0	1.00
2.00	Land Improvements	243,979	48,445	0	48,445	0	2.00
3.00	Buildings and Fixtures	607,623	96,661	0	96,661	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	129,683	0	0	0	0	5.00
6.00	Movable Equipment	13,523,498	314,273	0	314,273	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,529,783	459,379	0	459,379	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,529,783	459,379	0	459,379	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	25,000	0	1.00
2.00	Land Improvements	292,424	0	2.00
3.00	Buildings and Fixtures	704,284	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	129,683	0	5.00
6.00	Movable Equipment	13,837,771	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,989,162	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,989,162	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II Date/Time Prepared: 5/27/2015 9:33 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	0	0	0	0	104,114	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	986,245	0	0	30,815	0	2.00
3.00	Total (sum of lines 1-2)	986,245	0	0	30,815	104,114	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	104,114	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,017,060	2.00
3.00	Total (sum of lines 1-2)	0	1,121,174	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2015 9:33 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,151,391	0	1,151,391	0.076815	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,837,771	0	13,837,771	0.923185	0	2.00
3.00	Total (sum of lines 1-2)	14,989,162	0	14,989,162	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,134,674	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	986,245	52,147	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,120,919	52,147	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	104,114	0	1,238,788	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	154,064	30,815	0	0	1,223,271	2.00
3.00	Total (sum of lines 1-2)	154,064	30,815	104,114	0	2,462,059	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 9:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-3,658	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-17,427	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,142	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,653	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-816,564			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	-665,110			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	B	-1,687	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 9:33 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC REVENUE	B	-950	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	FACILITY FEES	B	-40,316	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISC REVENUE	B	-61,110	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MARKETING-EB	A	-745	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	MARKETING - A&G	A	-199,585	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MARKETING-RADIOLOGY	A	-1,251	OPERATING ROOM	50.00	0	33.05
33.06	BAD DEBT EXPENSE	A	-353,216	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	CHARITABLE CONTRIBUTIONS	A	-10,308	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.09	REBATES	B	-20	MEDICAL RECORDS & LIBRARY	16.00	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,175,742				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2015 9:33 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN EXPENSE	216	1,800,000	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BUILDING CAPITAL COSTS	1,134,674	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,134,890	1,800,000	5.00

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

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

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

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

6.00	G	MRA	100.00	PINNACLE HOSPITAL	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150166	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/27/2015 9:33 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-1,799,784	0		1.00
2.00	1,134,674	9		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-665,110			5.00

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

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

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

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

6.00	HEALTH CARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2015 9:33 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	53.00	ANESTHESIOLOGY	387,064	387,064	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	429,500	429,500	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			816,564	816,564	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	387,064		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	429,500		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	816,564		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,238,788	1,238,788				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,223,271		1,223,271			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	685,650	0	0	685,650		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,114,625	225,080	222,260	176,951	6,738,916	5.00
7.00	00700	OPERATION OF PLANT	598,076	134,977	133,287	3,730	870,070	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,609	6,526	0	13,135	8.00
9.00	00900	HOUSEKEEPING	136,223	0	0	8,014	144,237	9.00
10.00	01000	DIETARY	249,757	16,326	16,121	15,010	297,214	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	352,307	0	0	15,597	367,904	14.00
15.00	01500	PHARMACY	376,952	8,308	8,204	32,334	425,798	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	247,228	0	0	16,632	263,860	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,395,169	255,535	252,334	117,726	2,020,764	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,177,842	429,504	424,124	109,023	2,140,493	50.00
53.00	05300	ANESTHESIOLOGY	7	0	0	0	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	602,186	103,113	101,822	47,384	854,505	54.00
60.00	06000	LABORATORY	65,385	9,074	8,961	0	83,420	60.00
65.00	06500	RESPIRATORY THERAPY	336,150	1,616	1,596	27,668	367,030	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,571,431	0	0	0	1,571,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,001,653	0	0	0	5,001,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	342,811	0	0	0	342,811	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	173,074	48,646	48,036	12,594	282,350	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,888,585	1,238,788	1,223,271	582,663	21,785,598	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,891,125	0	0	102,987	1,994,112	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,779,710	1,238,788	1,223,271	685,650	23,779,710	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,738,916					5.00
7.00	00700	OPERATION OF PLANT	344,076	1,214,146				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,194	9,132	27,461			8.00
9.00	00900	HOUSEKEEPING	57,040	0	0	201,277		9.00
10.00	01000	DIETARY	117,536	22,557	0	3,768	441,075	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	145,491	0	0	0	0	14.00
15.00	01500	PHARMACY	168,385	11,479	0	1,917	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	104,346	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	799,127	353,074	27,461	58,975	441,075	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	846,475	593,447	0	99,126	0	50.00
53.00	05300	ANESTHESIOLOGY	3	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	337,921	142,472	0	23,797	0	54.00
60.00	06000	LABORATORY	32,989	12,538	0	2,094	0	60.00
65.00	06500	RESPIRATORY THERAPY	145,145	2,233	0	373	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	621,435	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,977,940	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,567	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	111,658	67,214	0	11,227	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,950,328	1,214,146	27,461	201,277	441,075	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	788,588	0	0	0	0	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,738,916	1,214,146	27,461	201,277	441,075	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	513,395				14.00
15.00	01500	PHARMACY	0	0	607,579			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	368,206		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	24,233	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	107,569	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,236	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	37,988	0	54.00
60.00	06000	LABORATORY	0	0	0	3,757	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,939	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	513,395	0	44,906	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	129,940	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	607,579	13,372	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	0	0	0	2,266	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	513,395	607,579	368,206	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0	194.00
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)	0	513,395	607,579	368,206	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,724,709	0	3,724,709		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,787,110	0	3,787,110		50.00
53.00	05300	ANESTHESIOLOGY	2,246	0	2,246		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,396,683	0	1,396,683		54.00
60.00	06000	LABORATORY	134,798	0	134,798		60.00
65.00	06500	RESPIRATORY THERAPY	516,720	0	516,720		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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,751,167	0	2,751,167		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,109,533	0	7,109,533		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,329	0	1,099,329		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	URGENT CARE	474,715	0	474,715		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,997,010	0	20,997,010		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,782,700	0	2,782,700		192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	23,779,710	0	23,779,710		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	225,080	222,260	447,340	0	5.00
7.00	00700	OPERATION OF PLANT	0	134,977	133,287	268,264	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,609	6,526	13,135	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	16,326	16,121	32,447	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	8,308	8,204	16,512	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	255,535	252,334	507,869	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	429,504	424,124	853,628	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	103,113	101,822	204,935	0	54.00
60.00	06000	LABORATORY	0	9,074	8,961	18,035	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,616	1,596	3,212	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
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
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	0	48,646	48,036	96,682	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,238,788	1,223,271	2,462,059	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,238,788	1,223,271	2,462,059	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	447,340					5.00
7.00	00700	OPERATION OF PLANT	22,840	291,104				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	345	2,189	15,669			8.00
9.00	00900	HOUSEKEEPING	3,786	0	0	3,786		9.00
10.00	01000	DIETARY	7,802	5,408	0	71	45,728	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,658	0	0	0	0	14.00
15.00	01500	PHARMACY	11,178	2,752	0	36	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,927	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,047	84,653	15,669	1,109	45,728	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	56,190	142,287	0	1,865	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,432	34,159	0	448	0	54.00
60.00	06000	LABORATORY	2,190	3,006	0	39	0	60.00
65.00	06500	RESPIRATORY THERAPY	9,635	535	0	7	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,252	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	131,300	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,999	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	7,412	16,115	0	211	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	394,993	291,104	15,669	3,786	45,728	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,347	0	0	0	0	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	447,340	291,104	15,669	3,786	45,728	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	14.00	15.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,658				14.00
15.00	01500	PHARMACY	0	0	30,478			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	6,927		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	457		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,028		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	42		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	716		54.00
60.00	06000	LABORATORY	0	0	0	71		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	37		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,658	0	847		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,434		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	30,478	252		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	0	0	0	43		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	9,658	30,478	6,927	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0		194.00
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)	0	9,658	30,478	6,927	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	708,532	0	708,532		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,055,998	0	1,055,998		50.00
53.00	05300	ANESTHESIOLOGY	42	0	42		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	262,690	0	262,690		54.00
60.00	06000	LABORATORY	23,341	0	23,341		60.00
65.00	06500	RESPIRATORY THERAPY	13,426	0	13,426		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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,757	0	51,757		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	133,734	0	133,734		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,729	0	39,729		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	URGENT CARE	120,463	0	120,463		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,409,712	0	2,409,712		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,347	0	52,347		192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,462,059	0	2,462,059		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	59,793					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		59,793				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,899,431			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,864	10,864	1,780,616	-6,738,916	17,040,794	5.00
7.00	00700	OPERATION OF PLANT	6,515	6,515	37,535	0	870,070	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	319	319	0	0	13,135	8.00
9.00	00900	HOUSEKEEPING	0	0	80,640	0	144,237	9.00
10.00	01000	DIETARY	788	788	151,036	0	297,214	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	156,946	0	367,904	14.00
15.00	01500	PHARMACY	401	401	325,365	0	425,798	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	167,360	0	263,860	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,334	12,334	1,184,626	0	2,020,764	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,731	20,731	1,097,054	0	2,140,493	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,977	4,977	476,802	0	854,505	54.00
60.00	06000	LABORATORY	438	438	0	0	83,420	60.00
65.00	06500	RESPIRATORY THERAPY	78	78	278,407	0	367,030	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,571,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,001,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	342,811	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	2,348	2,348	126,724	0	282,350	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,793	59,793	5,863,111	-6,738,916	15,046,682	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,036,320	0	1,994,112	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,238,788	1,223,271	685,650		6,738,916	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.717944	20.458432	0.099378		0.395458	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		447,340	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.026251	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	42,414					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	319	122,000				8.00
9.00	00900	HOUSEKEEPING	0	0	42,095			9.00
10.00	01000	DIETARY	788	0	788	100		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	401	0	401	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,334	122,000	12,334	100	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,731	0	20,731	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,977	0	4,977	0	0	54.00
60.00	06000	LABORATORY	438	0	438	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	78	0	78	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
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
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	2,348	0	2,348	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,414	122,000	42,095	100	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,214,146	27,461	201,277	441,075	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.626067	0.225090	4.781494	4,410.750000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	291,104	15,669	3,786	45,728	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.863394	0.128434	0.089939	457.280000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 9:33 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	75,461,910			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,966,698			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	22,047,430	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	458,238	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,786,114	0		54.00
60.00	06000	LABORATORY	0	0	770,117	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	397,465	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100	0	9,203,977	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	26,626,758	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	2,740,769	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	0	0	464,344	0		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	75,461,910	0		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	INDIANA BREAST CENTER	0	0	0	0		194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	513,395	607,579	368,206	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5,133.950000	6,075.790000	0.004879	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,658	30,478	6,927	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	96.580000	304.780000	0.000092	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 9:33 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	3,724,709		3,724,709	0	3,724,709	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,787,110		3,787,110	0	3,787,110	50.00
53.00	05300	ANESTHESIOLOGY	2,246		2,246	0	2,246	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,396,683		1,396,683	0	1,396,683	54.00
60.00	06000	LABORATORY	134,798		134,798	0	134,798	60.00
65.00	06500	RESPIRATORY THERAPY	516,720	0	516,720	0	516,720	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,751,167		2,751,167	0	2,751,167	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,109,533		7,109,533	0	7,109,533	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,329		1,099,329	0	1,099,329	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	474,715		474,715	0	474,715	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	430,115		430,115		430,115	92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	21,427,125	0	21,427,125	0	21,427,125	200.00
201.00		Less Observation Beds	430,115		430,115		430,115	201.00
202.00		Total (see instructions)	20,997,010	0	20,997,010	0	20,997,010	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 9:33 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	4,326,005		4,326,005			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,521,686	15,525,744	22,047,430	0.171771	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	55,181	403,057	458,238	0.004901	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,184,009	6,602,105	7,786,114	0.179381	0.000000	54.00
60.00	06000	LABORATORY	487,655	282,462	770,117	0.175036	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	295,997	101,468	397,465	1.300039	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,384,947	4,819,030	9,203,977	0.298911	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,234,605	3,392,153	26,626,758	0.267007	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,782,889	957,880	2,740,769	0.401102	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	18,153	446,191	464,344	1.022335	0.000000	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,662	572,031	640,693	0.671328	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	42,359,789	33,102,121	75,461,910			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,359,789	33,102,121	75,461,910			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 9:33 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.171771		50.00
53.00	05300	ANESTHESIOLOGY	0.004901		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179381		54.00
60.00	06000	LABORATORY	0.175036		60.00
65.00	06500	RESPIRATORY THERAPY	1.300039		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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.298911		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.267007		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.401102		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.01	09001	URGENT CARE	1.022335		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.671328		92.00
		SPECIAL PURPOSE COST CENTERS			
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,724,709		3,724,709	0	3,724,709	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,787,110		3,787,110	0	3,787,110	50.00
53.00	05300	ANESTHESIOLOGY	2,246		2,246	0	2,246	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,396,683		1,396,683	0	1,396,683	54.00
60.00	06000	LABORATORY	134,798		134,798	0	134,798	60.00
65.00	06500	RESPIRATORY THERAPY	516,720	0	516,720	0	516,720	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,751,167		2,751,167	0	2,751,167	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,109,533		7,109,533	0	7,109,533	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,329		1,099,329	0	1,099,329	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	474,715		474,715	0	474,715	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	430,115		430,115		430,115	92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	21,427,125	0	21,427,125	0	21,427,125	200.00
201.00		Less Observation Beds	430,115		430,115		430,115	201.00
202.00		Total (see instructions)	20,997,010	0	20,997,010	0	20,997,010	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 9:33 pm

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		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	4,326,005		4,326,005			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,521,686	15,525,744	22,047,430	0.171771	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	55,181	403,057	458,238	0.004901	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,184,009	6,602,105	7,786,114	0.179381	0.000000	54.00
60.00	06000	LABORATORY	487,655	282,462	770,117	0.175036	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	295,997	101,468	397,465	1.300039	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,384,947	4,819,030	9,203,977	0.298911	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,234,605	3,392,153	26,626,758	0.267007	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,782,889	957,880	2,740,769	0.401102	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	18,153	446,191	464,344	1.022335	0.000000	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	68,662	572,031	640,693	0.671328	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	42,359,789	33,102,121	75,461,910			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,359,789	33,102,121	75,461,910			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.171771		50.00
53.00	05300	ANESTHESIOLOGY	0.004901		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179381		54.00
60.00	06000	LABORATORY	0.175036		60.00
65.00	06500	RESPIRATORY THERAPY	1.300039		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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.298911		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.267007		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.401102		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.01	09001	URGENT CARE	1.022335		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.671328		92.00
		SPECIAL PURPOSE COST CENTERS			
114.00	11400	UTILIZATION REVIEW-SNF			114.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,787,110	1,055,998	2,731,112	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,246	42	2,204	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,396,683	262,690	1,133,993	0	0	54.00
60.00	06000	LABORATORY	134,798	23,341	111,457	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	516,720	13,426	503,294	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,751,167	51,757	2,699,410	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,109,533	133,734	6,975,799	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,329	39,729	1,059,600	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	474,715	120,463	354,252	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	430,115	81,819	348,296	0	0	92.00
		SPECIAL PURPOSE COST CENTERS						
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (sum of lines 50 thru 199)	17,702,416	1,782,999	15,919,417	0	0	200.00
201.00		Less Observation Beds	430,115	81,819	348,296	0	0	201.00
202.00		Total (line 200 minus line 201)	17,272,301	1,701,180	15,571,121	0	0	202.00

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

Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II | Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,787,110	22,047,430	0.171771		50.00
53.00	05300	ANESTHESIOLOGY	2,246	458,238	0.004901		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,396,683	7,786,114	0.179381		54.00
60.00	06000	LABORATORY	134,798	770,117	0.175036		60.00
65.00	06500	RESPIRATORY THERAPY	516,720	397,465	1.300039		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,751,167	9,203,977	0.298911		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,109,533	26,626,758	0.267007		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,329	2,740,769	0.401102		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	URGENT CARE	474,715	464,344	1.022335		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	430,115	640,693	0.671328		92.00
		SPECIAL PURPOSE COST CENTERS					
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (sum of lines 50 thru 199)	17,702,416	71,135,905			200.00
201.00		Less Observation Beds	430,115	0			201.00
202.00		Total (line 200 minus line 201)	17,272,301	71,135,905			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/27/2015 9:33 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	708,532	0	708,532	2,927	242.07	30.00
200.00	Total (lines 30-199)	708,532		708,532	2,927		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	1,078	260,951				30.00
200.00	Total (lines 30-199)	1,078	260,951				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 9:33 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	1,055,998	22,047,430	0.047897	2,438,260	116,785	50.00
53.00	05300	ANESTHESIOLOGY	42	458,238	0.000092	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	262,690	7,786,114	0.033738	679,409	22,922	54.00
60.00	06000	LABORATORY	23,341	770,117	0.030308	285,682	8,658	60.00
65.00	06500	RESPIRATORY THERAPY	13,426	397,465	0.033779	155,676	5,259	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,757	9,203,977	0.005623	1,519,130	8,542	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	133,734	26,626,758	0.005023	8,874,521	44,577	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,729	2,740,769	0.014496	819,071	11,873	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	120,463	464,344	0.259426	11,025	2,860	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,819	640,693	0.127704	68,662	8,768	92.00
200.00		Total (lines 50-199)	1,782,999	71,135,905		14,851,436	230,244	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/27/2015 9:33 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
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	2,927	0.00	1,078	0		30.00
200.00		Total (lines 30-199)	2,927		1,078	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 9:33 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
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
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 9:33 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	22,047,430	0.000000	0.000000	2,438,260	50.00
53.00	05300	ANESTHESIOLOGY	0	458,238	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,786,114	0.000000	0.000000	679,409	54.00
60.00	06000	LABORATORY	0	770,117	0.000000	0.000000	285,682	60.00
65.00	06500	RESPIRATORY THERAPY	0	397,465	0.000000	0.000000	155,676	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,203,977	0.000000	0.000000	1,519,130	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,626,758	0.000000	0.000000	8,874,521	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,740,769	0.000000	0.000000	819,071	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	0	464,344	0.000000	0.000000	11,025	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	640,693	0.000000	0.000000	68,662	92.00
200.00		Total (lines 50-199)	0	71,135,905			14,851,436	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 9:33 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	3,899,468	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,770,276	0		54.00
60.00	06000	LABORATORY	0	208,322	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	16,117	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,217,922	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,086,614	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	269,663	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	URGENT CARE	0	43,886	0		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	149,072	0		92.00
200.00		Total (lines 50-199)	0	8,661,340	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 9:33 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	0.171771	3,899,468	0	0	669,816	50.00
53.00	05300	ANESTHESIOLOGY	0.004901	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179381	1,770,276	0	0	317,554	54.00
60.00	06000	LABORATORY	0.175036	208,322	0	0	36,464	60.00
65.00	06500	RESPIRATORY THERAPY	1.300039	16,117	0	0	20,953	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.298911	1,217,922	0	0	364,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.267007	1,086,614	0	0	290,134	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.401102	269,663	0	0	108,162	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	1.022335	43,886	0	0	44,866	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.671328	149,072	0	0	100,076	92.00
200.00		Subtotal (see instructions)		8,661,340	0	0	1,952,075	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		8,661,340	0	0	1,952,075	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 9:33 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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	URGENT CARE	0	0		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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	708,532	0	708,532	2,927	242.07	30.00
200.00	Total (lines 30-199)	708,532		708,532	2,927		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	65	15,735				30.00
200.00	Total (lines 30-199)	65	15,735				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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	1,055,998	22,047,430	0.047897	11,833	567	50.00
53.00	05300	ANESTHESIOLOGY	42	458,238	0.000092	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	262,690	7,786,114	0.033738	21,210	716	54.00
60.00	06000	LABORATORY	23,341	770,117	0.030308	13,495	409	60.00
65.00	06500	RESPIRATORY THERAPY	13,426	397,465	0.033779	7,802	264	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,757	9,203,977	0.005623	30,382	171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	133,734	26,626,758	0.005023	11,046	55	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,729	2,740,769	0.014496	42,805	621	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	120,463	464,344	0.259426	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,819	640,693	0.127704	0	0	92.00
200.00		Total (lines 50-199)	1,782,999	71,135,905		138,573	2,803	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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
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	2,927	0.00	65	0		30.00
200.00		Total (lines 30-199)	2,927		65	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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
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
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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	22,047,430	0.000000	0.000000	11,833	50.00
53.00	05300	ANESTHESIOLOGY	0	458,238	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,786,114	0.000000	0.000000	21,210	54.00
60.00	06000	LABORATORY	0	770,117	0.000000	0.000000	13,495	60.00
65.00	06500	RESPIRATORY THERAPY	0	397,465	0.000000	0.000000	7,802	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,203,977	0.000000	0.000000	30,382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,626,758	0.000000	0.000000	11,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,740,769	0.000000	0.000000	42,805	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	0	464,344	0.000000	0.000000	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	640,693	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	71,135,905			138,573	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
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
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	URGENT CARE	0	0	0		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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	0.171771	0	124,823	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.004901	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179381	0	137,335	0	0	54.00
60.00	06000	LABORATORY	0.175036	0	10,308	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.300039	0	406	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.298911	0	75,991	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.267007	0	19,737	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.401102	0	8,509	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	URGENT CARE	1.022335	0	276	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.671328	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	377,385	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	377,385	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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	21,441	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,635	0		54.00
60.00	06000	LABORATORY	1,804	0		60.00
65.00	06500	RESPIRATORY THERAPY	528	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,715	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,270	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,413	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	URGENT CARE	282	0		90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	80,088	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	80,088	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 9:33 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)	2,927	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,927	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,589	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)	1,078	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)	3,724,709	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)	3,724,709	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)	3,724,709	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)	1,272.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,371,787	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)	1,371,787	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 9:33 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	4,002,626	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,374,413	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)	260,951	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	230,244	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	491,195	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,883,218	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)	338	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,272.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	430,115	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 9:33 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	708,532	3,724,709	0.190225	430,115	81,819	90.00
91.00	Nursing School cost	0	3,724,709	0.000000	430,115	0	91.00
92.00	Allied health cost	0	3,724,709	0.000000	430,115	0	92.00
93.00	All other Medical Education	0	3,724,709	0.000000	430,115	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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)	2,927	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,927	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,589	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)	65	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)	3,724,709	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)	3,724,709	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)	3,724,709	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)	1,272.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	82,714	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)	82,714	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	47,543	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	130,257	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)	15,735	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,803	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	18,538	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	111,719	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)	338	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,272.53	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	430,115	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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	708,532	3,724,709	0.190225	430,115	81,819	90.00
91.00	Nursing School cost	0	3,724,709	0.000000	430,115	0	91.00
92.00	Allied health cost	0	3,724,709	0.000000	430,115	0	92.00
93.00	All other Medical Education	0	3,724,709	0.000000	430,115	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 9:33 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		1,911,248		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171771	2,438,260	418,822	50.00
53.00	05300	ANESTHESIOLOGY	0.004901	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179381	679,409	121,873	54.00
60.00	06000	LABORATORY	0.175036	285,682	50,005	60.00
65.00	06500	RESPIRATORY THERAPY	1.300039	155,676	202,385	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.298911	1,519,130	454,085	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.267007	8,874,521	2,369,559	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.401102	819,071	328,531	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	URGENT CARE	1.022335	11,025	11,271	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.671328	68,662	46,095	92.00
200.00		Total (sum of lines 50-94 and 96-98)		14,851,436	4,002,626	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)		14,851,436		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 9:33 pm

Title XIX | 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		5,853		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171771	11,833	2,033	50.00
53.00	05300	ANESTHESIOLOGY	0.004901	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179381	21,210	3,805	54.00
60.00	06000	LABORATORY	0.175036	13,495	2,362	60.00
65.00	06500	RESPIRATORY THERAPY	1.300039	7,802	10,143	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.298911	30,382	9,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.267007	11,046	2,949	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.401102	42,805	17,169	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	URGENT CARE	1.022335	0	0	90.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.671328	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		138,573	47,543	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)		138,573		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/27/2015 9:33 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)		0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,032,260		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)		1,828,356		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		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		17.07		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)		0.00		30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00		31.00
32.00	Sum of lines 30 and 31		0.00		32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00		33.00
34.00	Disproportionate share adjustment (see instructions)		0		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A | Date/Time Prepared: 5/27/2015 9:33 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)		0.000003404	0.000001562	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		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)		3,860,616		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)		3,860,616		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		446,766		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)		4,307,382		59.00
60.00	Primary payer payments		10,874		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,296,508		61.00
62.00	Deductibles billed to program beneficiaries		273,504		62.00
63.00	Coinsurance billed to program beneficiaries		3,344		63.00
64.00	Allowable bad debts (see instructions)		0		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		0		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,019,660		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)		-7,623		70.93
70.94	HRR adjustment amount (see instructions)		-15,783		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150166	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/27/2015 9:33 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)		3,996,254		71.00
71.01	Sequestration adjustment (see instructions)		79,925		71.01
72.00	Interim payments		3,916,329		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)		0		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150166	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 9:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,952,075	2.00
3.00	PPS payments	1,533,278	3.00
4.00	Outlier payment (see instructions)	43,190	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,576,468	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)	335,868	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)	1,240,600	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)	1,240,600	30.00
31.00	Primary payer payments	196	31.00
32.00	Subtotal (line 30 minus line 31)	1,240,404	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)	1,240,404	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)	1,240,404	40.00
40.01	Sequestration adjustment (see instructions)	24,808	40.01
41.00	Interim payments	1,215,596	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 9:33 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		3,916,329		1,215,596	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)		3,916,329		1,215,596	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,916,329		1,215,596	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150166	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/27/2015 9:33 pm
	Title XIX	Hospital	PPS

		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	0		1.00
2.00	Medical and other services		80,088	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	80,088	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)	0	80,088	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	5,853		8.00
9.00	Ancillary service charges	138,573	377,385	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)	144,426	377,385	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)	144,426	377,385	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	144,426	297,297	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)	0	80,088	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)	0	80,088	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)	0	80,088	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)	0	80,088	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	80,088	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)	0	80,088	40.00
41.00	Interim payments	0	80,088	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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/27/2015 9:33 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	2,141,323	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	4,622,088	0	0	0	4.00
5.00	Other receivable	101,370	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	609,483	0	0	0	7.00
8.00	Prepaid expenses	315,225	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,789,489	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	25,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	292,424	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	14,671,738	0	0	0	23.00
24.00	Accumulated depreciation	-12,555,366	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,433,796	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	142,797	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	142,797	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,366,082	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,938,728	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,575,488	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,164,556	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	61,179	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,739,951	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	3,773,295	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	3,773,295	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	14,513,246	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-4,147,164				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)	-4,147,164	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,366,082	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/27/2015 9:33 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		-3,669,441		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-77,721				2.00
3.00	Total (sum of line 1 and line 2)		-3,747,162		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-3,747,162		0		11.00
12.00	PRIOR PERIOD ADJUSTMENT	400,002		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)		400,002		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-4,147,164		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	PRIOR PERIOD ADJUSTMENT		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: 150166 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2015 9:33 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,067,275		5,067,275	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,067,275		5,067,275	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,067,275		5,067,275	17.00
18.00	Ancillary services	37,853,556	32,077,148	69,930,704	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	URGENT CARE	18,485	452,224	470,709	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	1,195,914	1,195,914	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	42,939,316	33,725,286	76,664,602	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,955,452		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,955,452		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150166	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/27/2015 9:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	76,664,602	1.00
2.00	Less contractual allowances and discounts on patients' accounts	50,778,350	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,886,252	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,955,452	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-69,200	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,658	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	17,447	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	1,687	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	MISC INCOME	604,355	24.00
24.01	FACILITY FEES	40,316	24.01
25.00	Total other income (sum of lines 6-24)	667,463	25.00
26.00	Total (line 5 plus line 25)	598,263	26.00
27.00	BAD DEBT EXPENSE	675,984	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	675,984	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-77,721	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150166	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/27/2015 9:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	162,754	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	284,012	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)	7.09	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)	446,766	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